





RC602  
.B11

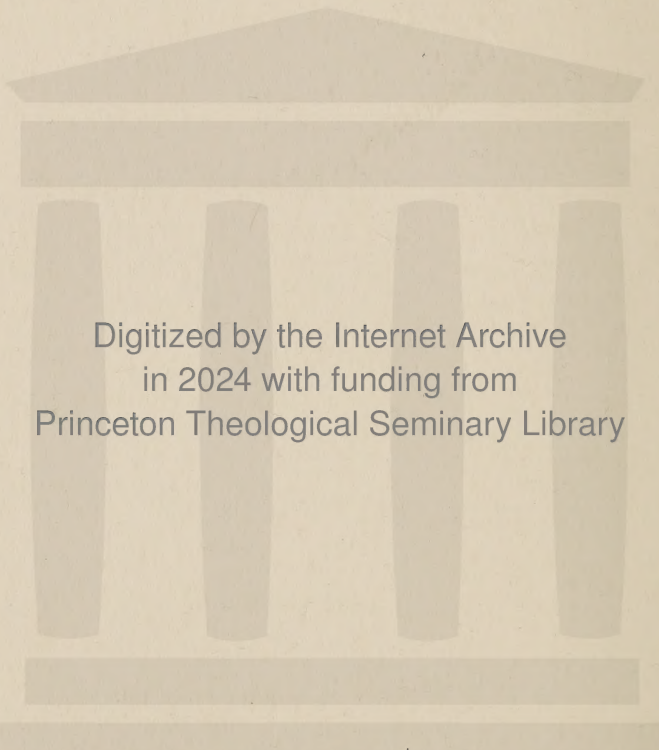












Digitized by the Internet Archive  
in 2024 with funding from  
Princeton Theological Seminary Library



# INTENSIVE GROUP PSYCHOTHERAPY

by

GEORGE R. BACH, Ph.D.

CLINICAL PSYCHOLOGIST; FORMERLY ASSISTANT  
PROFESSOR OF PSYCHOLOGY, UNIVERSITY OF SOUTHERN  
CALIFORNIA

THE RONALD PRESS COMPANY • NEW YORK

Copyright, 1954, by  
THE RONALD PRESS COMPANY

---

*All Rights Reserved*

The text of this publication or any part  
thereof may not be reproduced in any  
manner whatsoever without permission in  
writing from the publisher.

3 VB

Library of Congress Catalog Card Number: 54-6324

PRINTED IN THE UNITED STATES OF AMERICA



IN REMEMBRANCE OF MY TEACHER, THE LATE

KURT LEWIN

Pioneer in group dynamics and  
the experimental study of human relations



## PREFACE

---

This volume describes both the practice and the theory of intensive group psychotherapy, a relatively new and rapidly developing method of treating personality disorders. It is practical in describing clinical procedures, and yet it tries to come to terms with basic theoretical problems. Part I deals with clinical technique; Part II explores the nature of the therapeutic process that is fostered by group therapy participation; Part III examines the group dynamic forces that influence the therapeutic process in the individual.

Chiefly addressed to those practicing or contemplating the use of group psychotherapy, this volume with its insights into group dynamics should also be of value to social psychologists and social scientists interested in the interaction of individuals in groups.

Not long ago group therapy was seen as parallel to individual therapy. Essentially the same methods were used, with some concessions made to the practical problems of communication that arose when several persons met with the therapist. The author believes that although a few of the basic concepts developed by the individual approaches are extremely useful in clarifying some parts of the group therapeutic process, clinical experience in the *intensive* use of groups shows that a group therapist must have concepts that go beyond those employed in individual therapy.

When participating in groups, patients are affected by and give expression to unconscious forces that are not recognizable in individual treatment. Consequently, a group therapist not only must know how to recognize the dynamics of transference and ego defenses but must master an additional skill. He must be able to recognize, reflect, and interpret that set of psychological forces operating in group situations which the late Kurt Lewin started to investigate under the label of "group dynamics."

One of the aims of this book is to explore the possibility of applying Lewin's research findings to the clinician's task of effecting behavior changes in individuals with personality disorders. Combining the two disciplines of group dynamics and psychotherapy, this volume examines the many problems of clinical practice and suggests new conceptual tools.

Without the long-lasting influence of former teachers and colleagues, there would be no theoretical frame of reference to integrate the vast number of clinical observations. And to my present colleagues and friends, I wish to express my gratitude for their intellectual stimulation and constant encouragement. All those individuals who remain unnamed must accept the spirit of being credited with whatever merit this book may have. For more specific assistance the author is happy to acknowledge his indebtedness to the following: Dr. S. M. Wesley, for reading and criticizing the first draft of the manuscript; Dr. Leon Festinger, Professor of Psychology, Laboratory for Research in Social Relations, University of Minnesota, for reading Part III of the first draft; Dr. Dorwin Cartwright, Research Institute for Group Dynamics, University of Michigan, for reading the draft of Chapter 20 and for granting permission to use his eight principles for "achieving change in people"; Drs. Charlotte and Karl Bühler for reading and criticizing drafts of Chapters 16 and 19.

I am particularly grateful to the students and faculty members of the University of Southern California for their stimulating reactions to my observations which I presented in seminars on "Group Dynamics and Psychotherapy." In my own clinical practice the patients of two therapy groups who were sampled out for intensive study not only allowed their communications to be recorded and to be partially reproduced in the protocols and drawings, but they creatively contributed to making explicit their participant observations.

Abe Abarbanel, M.D., Arthur Chandler, M.D., Robert Welden, M.D., Barbara Halpern, M.D., Richard Halpern, M.D., and Henry H. Henstell, M.D., provided medical care of some of the patients participating in the group therapy program.

I should like to thank Nellie Young Twombly and Billie



Arnold for secretarial assistance in preparation of the many-versioned manuscript and bibliography.

Peggy Jane Bach gracefully tolerated the intrusion of a technical manuscript into our social and family life. Last, but not least, I wish to thank my children, Roger, Claudia, Stephanie, and Felicity, for respecting the times when their father needed solitude.

GEORGE R. BACH

Beverly Hills, Calif.

January, 1954



# CONTENTS

---

## PART I

### CLINICAL TECHNIQUES

CHAPTER		PAGE
1	INTRODUCTORY ORIENTATION TO GROUP PSYCHOTHER- APY . . . . .	3
2	DIAGNOSIS AND SELECTION OF THERAPY GROUP MEM- BERS . . . . .	12
3	PREPARATION AND INTRODUCTION OF NEW PATIENTS	28
4	MANAGEMENT OF EARLY RESISTANCE . . . . .	36
5	COMBINING INDIVIDUAL AND GROUP SESSIONS . . .	50
6	MAJOR VEHICLES AND THEMES OF GROUP COMMUNI- CATION . . . . .	67
7	SPONTANEOUS DISCUSSIONS: FACTS RELATING TO PER- SONAL HISTORY . . . . .	81
8	SPONTANEOUS ACTIVITIES: ADVISING AND SOCIALIZ- ING . . . . .	94
9	CLINICALLY INSTIGATED PROJECTIVE COMMUNICA- TIONS: DREAMS AND DRAWINGS . . . . .	121
10	IMPROMPTU ROLE PLAYING . . . . .	152
11	GROUP AWARENESS: SANCTION AND SELF-REGULATION	165
12	OBSERVATIONS OF THERAPEUTIC GROWTH PROCESSES	192
13	OVERT ASPECTS OF THE THERAPIST'S ROLE . . .	204

## PART II

### THERAPEUTIC EFFECTS

14	ANALYSIS OF CONTACT OPERATIONS . . . . .	213
15	EGO GROWTH AND INDIVIDUAL SELF-DIFFERENTIATION	247

CHAPTER	PAGE
16	DEVELOPMENTAL PHASES IN THE THERAPEUTIC GROWTH PROCESS . . . . . 268
17	RESISTANCE AGAINST GROUP PRESSURE . . . . . 294

## PART III

FACTORS OF GROUP DYNAMICS IN THE  
THERAPEUTIC PROCESSES

18	MODELS AND CONCEPTS OF GROUP LIFE . . . . . 317
19	APPLICATION OF GROUP DYNAMIC PRINCIPLES . . . 344
20	CLINICAL SIGNIFICANCE OF GROUP TENSION . . . 362
21	GROUP TENSIONS RAISED BY LEADERS AND BY ISO- LATES . . . . . 375
22	SUBGROUPING AND MAJORITY CONSENSUS . . . . 394
	BIBLIOGRAPHY . . . . . 415
	INDEX OF NAMES . . . . . 431
	INDEX OF SUBJECTS . . . . . 433



## PROTOCOLS

---

	PAGE
No. 1. A New Patient's Reactions to Her First Group Therapy Session . . . . .	32
No. 2. Therapist's First Active Participation—Summa- rizing Group Emotions . . . . .	43
No. 3. "Drainage" in Private Sessions . . . . .	57
No. 4. "Mother" . . . . .	83
No. 5. Individual Session with Patient H-F Six Weeks After Group Protocol, "Mother" . . . . .	89
No. 6. Reactivation . . . . .	92
No. 7. Example of Theme 13—Discussion of a Birthday Party . . . . .	109
No. 8. "Do Not Mix Therapy with Social Life" . . . . .	118
No. 9. Dream Reporting . . . . .	125
No. 10. H-F's First Dream . . . . .	129
No. 11. H-F's Second Dream . . . . .	129
No. 12. H-F's Third Dream . . . . .	130
No. 13. Impromptu Role Acting . . . . .	153
No. 14. Reaction to a Therapist's Directiveness . . . . .	170
No. 15. To Go or Not To "Go Around" . . . . .	173
No. 16. Group Reaction to a Resistant Narcissist . . . . .	305
No. 17. Differentiation of Family and Therapy Group . . . . .	321
No. 18. How the Group Attempts to Use a Newcomer to Solve Group Tension Over an Isolate . . . . .	382



# PART I

---

## OUTLINE OF CLINICAL TECHNIQUES





## Chapter 1

### INTRODUCTORY ORIENTATION TO GROUP PSYCHOTHERAPY

---

Participation in group psychotherapy is a unique experience in our culture for both patient and therapist. In no other social group situation is it safe and practical to formulate to the self and to share with others emotional experiences of a very personal nature. No other setting affords the opportunity to observe the self in interpersonal contact, to discover one's pattern of personality in social action, and to check private observations about oneself against the impressions of others. Therapy groups manifest a great variety of complex psychological phenomena. Even after working professionally with groups in a variety of settings for years, one never ceases to be amazed at the variability, complexity, and intensity of emotional and interpersonal processes that occur in therapy groups.

The fact that a number of emotionally disturbed individuals are willing, even eager, to meet as a group of strangers to expose their individual secrets and shortcomings is in itself remarkable. Is the pursuit of an explicit goal of self-improvement, an individualistic, private goal, enough to explain such grouping? What are the forces that govern the steady, regular participation in an intimate social activity of emotionally disturbed individuals? The group life seems to provide a type of gratification of personal needs which can only be provided by a group. Group living is, potentially, an ideal medium for increasing self-esteem, self-knowledge, and understanding of one's fellow men. But this psychotherapeutic potentiality, inherent in participation in a therapy group, can be realized only if the group life develops a clinical quality or a "work culture." Otherwise the group may function merely as an opportunity or stage for defensive self-

assertion, exhibitionism, psychological voyeurism, or sadomasochistic direction-giving and "analyzing."

Therapy groups do not develop a therapeutic work culture without a professional therapist-leader who understands not only the transference process, personality structure, and defense mechanisms, but who is also perceptive of group dynamics and interpersonal communication problems. A professional psychologist is needed by a therapy group to assist the often quite disturbed members to keep personal anxiety and group emotions within manageable proportions. Everyone is emotionally affected by group participation. The tendency of groups to elicit strong emotions permits patients to externalize and perceive usually unconscious aspects of their personality problems.

### The Search for New Concepts

No two therapy group sessions are ever the same. When the therapist's regular work schedule includes meeting with several different groups in diverse settings, it becomes obvious that the range and quality of behavior processes not only vary from group to group, but from session to session in the same group. Different physical settings—hospital, clinic, private practice—each produces a different group atmosphere. The situation becomes even more complicated by the fact that different psychotherapists have different personalities, "pet techniques," and different theoretical orientations. No wonder, then, that to many observers each therapy group meeting appears to be "unique" to the particular sample of patients, to the particular setting, and to the individual personality of the therapist. The task of this book is to search for general principles that may apply to a diversity of group therapy settings.

Being social scientists and not novelists, we cannot remain unduly concerned with the endless variety and complexity of therapy group life. We must believe that certain lawful processes operate beneath the surface of the complex group therapy phenomena. In order to communicate observations in such a way that they apply to a variety of group settings, general concepts must be used. These concepts must be specific enough so

that their validity can be checked by clinical experience and systematic research. The practitioner must try to translate that which he may have heard with his sensitive "third ear" into a conceptual language which permits the organization of perceptions made by the research scientist.

To do so is not easy. It takes courage to accept a set of working concepts with the full knowledge that they may later prove to be "erroneous." At our present stage of knowledge, concepts of group therapy life are little more than spotlights searching in the the night, illuminating only part of the road, penetrating little of the fog that blurs the many turns and twists of this new and unfamiliar path.

There is great need for the clarification of interpersonal psychology, of the relation of *contact* to the individual personality structure. The problem seems so complex that anyone attempting a clarification must feel presumptuous in offering his few suggestions. Most concepts now available originated in individual psychopathology and psychotherapy; because of this "intra-dermal" origin, they may not suggest the most appropriate way of conceptualizing group therapy processes. It is inevitable that we must add a new level of conceptualization without losing the lessons gained from the traditional personality frame of reference.

A differentiation of the group approach to psychotherapy from the traditional, individual approach is involved. Instead of attempting to force one's understanding of all the therapy processes occurring in a group setting into a Procrustean bed of concepts helpful in understanding individual therapy, it may be wiser to assume that although some of the group therapy processes are very similar, others are different and unique to the group medium.

### The Present Approach

In this volume both a method and a theory for the use of the small group as a vehicle for intensive psychotherapy for adult neurotic patients are presented. The approach is in part eclectic, in part "original." Our approach is eclectic in the sense that the writer's training in two different fields, hitherto considered anti-

thetical by many students, namely, psychoanalysis and field theory, has been merged with such modifications of each frame of reference as to make an integration practical. The part of the present work that may earn the term "original" is the effort to search seriously into the subtle and covert dynamics of therapy groups. This search is made with three questions in mind: (1) What therapeutic significance to the individual patient does a given process in group dynamics have? In other words, what can we learn about the therapeutic process occurring within the individual from an understanding of his participation in these group processes? (2) What practical implications for clinical technique and the better management of therapy groups are inherent in certain concepts of group life? (3) What implications concerning observations made in the practice of group psychotherapy can illuminate the more general theories of personality and interpersonal behavior?

Our procedure in this tripurpose approach is to give three kinds of information: (1) faithful reports of actual therapy group occurrences as they could be noticed by any trained observer, regardless of his theoretical orientation; (2) suggestions concerning the processes of group dynamics in terms of models and forces; that is, conceptual tools which have helped the author to integrate the mass of phenotypic data toward an order of genotypes; (3) a theoretical inquiry into the dynamic relationships that may be inferred between the processes of group dynamics and the therapeutic progress of the individual. To initiate this approach we shall turn our attention first to the physical characteristics of two sample groups, taken from the author's group therapy practice.

The physical setting in which the office activities of our two sample groups took place is a good-sized (24' x 14') private office, an oblong air-conditioned room which is part of a suite in a medical office building. Wall-to-wall carpeting, drapes, and built-in bookshelves insure good acoustics. One part of the room contains the therapist's desk and swivel chair, a couch and one easy chair. This is the individual therapy section of the room. At the other end of the room is a large modern circular sofa, a coffee table (used mostly as a footrest), and four easy chairs. A



corner table with several plants helps to create an informal living room atmosphere. This is the group therapy section of the room. Eleven or twelve persons can be very comfortably seated, while a small group of five or six persons do not feel lost. In one corner a standing electro-voice microphone is available to the group for making wire recordings for playback and/or research purposes. Most group meetings are scheduled in the early evening. Since many members have just finished a long day of work and commuting, they feel like lounging in an informal manner. The men may remove their coats and ties, and both men and women often remove or loosen their shoes during the session.

Members are not indifferent to where they seat themselves. One can notice a tendency to seek or avoid certain places. The obviously most comfortable easy chair, "papa's chair," is assumed by new patients to be preferred by the therapist. As one patient recently remarked to the therapist, "You sit there! I can always remember my father taking the best chair in the room!"

For certain activities such as the psychodrama, the physical setting must go beyond that of a room just large enough to seat ten individuals. The division of the group into audience and actors requires a doubling of the minimal space necessary for the conference or round-table type of group therapy discussion. Ideally, a group therapist should have available a room large enough to have a section for informal psychodrama in addition to the space for the regular round-table discussion activity. There should be some extra space in which to move about for the active dramatic types of role-playing activity.

The most popular group seating arrangement is the circle. Research shows that persons sitting *opposite* each other have the greatest stimulus value for each other (Steinzor, 1950). Interpersonal traffic is facilitated by the opportunity to observe non-verbal facets of communication, such as gestures, postures, and the total physical contour.

In this setting Sample Group I, during a sample calendar year (1951), had fifty meetings, and during the same time Group II had ninety-seven meetings. Group I met once a week, Group II had two weekly sessions. The two-hour office sessions were always followed, as part of the therapy program, by another two-

hour "post-session." That is, after the office meeting the groups gathered to have dinner at a nearby restaurant. These post-sessions were not attended by the therapist.

At the time of this writing, Group I has had a life span of seven years. All of the seven starting members have since "graduated."

TABLE I

MONTHLY HOURS OF GROUP AND INDIVIDUAL THERAPY  
CONTACT FOR PRESENT MEMBERS OF GROUP II (APRIL, 1952)

1 Patient	2 Sex	3	4	5	6	7	8
		Present Schedule			Totals to Date		
		Ind. Hours per Month	Group Hours per Month	Group Sessions per Month	No. of Group Sessions	Hours of Group Contact	Ind. Hours
II-M *	F	0	36	9	172	688	140
II-K	F	9	36	9	215	860	303
II-X	F	4	36	9	30	120	40
II-P	M	0	36	9	172	688	82
II-L *	M	1	36	9	172	688	226
II-V	F	4	36	9	48	192	63
II-W	M	2	28	7	31	144	65
II-Z	M	4	36	9	11	44	41
II-Y	F	4	36	9	4	16	14

\* Patient had one to three years of intensive individual psychotherapy elsewhere before entering our program.

Group II has been in continuous session for five years. Of the original membership of eight patients, three are still with the group. The others have been replaced by newcomers. Inspection of Table I will give the reader an impression of the degree of intensity of the monthly therapy schedule of those members of sample Group II who were active participants at a given time (April, 1952). This group meets twice weekly, each time for two office hours, which are followed by at least two hours of "post-sessions." Except for the patient (II-W) who missed one week, there were no absentees during the month, so that the majority of patients had 36 hours of group contact, a typical picture for most intensive groups. The hours of individual contact with the therapist are shown in Columns 3 and 8 of Table I. Again there are considerable individual differences, reflecting the fact

that while some patients make good progress without individually seeing the therapist regularly, most patients seek individual sessions in addition to their group participation.

Group therapy participants leave after varying periods of participation. Sixty per cent of the membership of Group II had fewer than 150 group therapy sessions. The number of hours of group contact ranges from one patient who left after 16 hours to another who participated in 860 hours of group contact. It would be meaningless to give an average number of hours of attendance because such a number would be a very arbitrary point in a great range. We have had severely neurotic patients who considered themselves ready to "graduate" after feeling they had mastered their initial complaints in fewer than twenty group therapy sessions. On the other hand there are patients who have participated for many years.

Absences were infrequent in the two sample groups. When they occurred, they were never taken lightly by either the present members or the absent ones. Usually every patient makes a strong effort not to miss a meeting. Most absences are due to unavoidable causes, such as illness, being out of town for business purposes, vacations, and the like.

### Problems of Objective Description

It is difficult to describe the longitudinal growth character of the group therapy process by means of selected protocols, which give a momentary cross section only. This is a misleading way of giving a descriptive case history of group therapy life. It would be as impossible to illustrate the quality and technique of one of Turner's landscape paintings, for example, by cutting from the total canvas a square inch here and a square inch there and reproducing the sectional pieces in an art book to "illustrate" the whole. Sectional protocols cannot possibly illustrate the totality of even certain natural subphases of group therapy life. Protocols can illuminate details only. They distort by putting into the foreground some parts which derive meaning only from the whole. For this reason protocols are used sparingly in this volume and it is assumed that when and where we make use of them,



the reader will guard against the tendency to make generalizations concerning the whole process from a given detail.

Therapy groups are ceaselessly engaged in what Murray (1951) has termed "transformative functional operations." The temporal dimension is a necessary perspective to the understanding of life in the therapy group. There is a continuous maintenance of the group, to which the various ongoings that can be easily observed are related in the same way that the crests of the waves are related to the changing tides of the entire ocean.

In reading descriptions of group therapy life in this volume, it may be helpful to think in terms of various levels of description or analysis as pertaining to parts of a total process of group life which, as a whole, is as yet undefinable. At this stage of our knowledge of this new field, only confusion will result from attempts to assemble the various levels of analysis into one complete conceptual picture.

We shall describe some repeatedly observable group therapy occurrences and techniques, keeping in mind that such descriptions may represent merely this particular observer's present adjustment to his task. Several other observers have described group therapy processes from quite different frames of reference. For example, Foulkes' (1948, 1951*a*) descriptions draw attention particularly to the leader role of the therapist, as do Powdermaker and Frank's (1953). Slavson (1950*a*), on the other hand, describes the therapeutic process mediated by group therapy participation in terms of identification, transference, and other psychoanalytic concepts involved in the description of intensive individual analysis. Wolf (1949-50) draws attention to the process through which the individual patient by identifying with the "group ego" frees himself for deeper analytic explorations than appear possible in individual psychoanalysis. Bion's (1948-51) speculative description of the "group mentality" of therapy groups contains some observations which closely overlap our own. Ezriel (1950*b*, 1952) and Sutherland (1952), both associated with the Tavistock Institute in London, apply the "here-and-now" frame of reference, by which they understand the patient's quality of participation in the group as demonstrating the particular de-

fense mechanisms used by the individual to deal with unconscious conflicts within himself.

The history of group psychotherapy, while brief, is by no means barren; the literature contains over 1,000 published contributions to date. Beginning with the pioneer contributions to the systematic description of group psychotherapy by Moreno, by Burrow, and by Schilder, every recent investigator of the complexity of group therapy phenomena has noted that being part and parcel of the group life process is at once essential to participant observations, while at the same time limiting scientific objectivity.

As an aid to staying as close as possible to objective descriptions of our experience and observation, we have used several rather than one frame of reference. In other words, we have tried to go over the same ground or the same data, with several kinds of conceptual tools. We are certain that our own blind spots left much of the ground totally untouched, while at the same time overworking some particularly fascinating spots. Yet we have, perhaps, achieved some freedom from theoretical rigidity and tradition-bound concepts.



## Chapter 2

### DIAGNOSIS AND SELECTION OF THERAPY GROUP MEMBERS

---

The group approach is used in a large variety of settings where psychotherapeutic services are rendered. The three major settings are the psychiatric hospital, the community or university clinic, and the private consulting practice. While the background material of this book is based on clinical and research experience in all three settings, the specific examples and practical techniques are drawn from the author's private consulting practice. In private practice intensive group therapy occurs under conditions of keen alertness to therapeutic efficiency on the part of both the therapist and the fee-paying patient. This facilitates the recognition of clinically and systematically important group therapy phenomena.

We have chosen to describe the application of the group to an *intensive* type of psychotherapy, not because the author believes that all psychotherapy should be intensive, but rather that in the intensive process all the nuances possibly present in less intensive treatment situations can be studied in clearer detail.

Our groups are continuous therapy groups. In group therapy one distinguishes between *closed* groups and *continuous* groups. A closed group maintains throughout its life the membership with which it started. A continuous group replaces any member who may leave by a new member. The membership number in the two groups which we shall use throughout this book as samples or models ranged from seven to nine patients in addition to the therapist. The actual attendance figure ranged from four to eight. In principle, every group member is also seen individually; in practice, however, many patients do not avail themselves of the opportunity to maintain regular individual contact with the group therapist.

## The Screening Technique

When a group of patients is used as a psychotherapeutic medium, careful screening is an essential clinical responsibility. But even the best screening and selection technique does not guarantee the success or failure of a group therapy program, for psychologically a therapy group is *more* than the sum of carefully selected individual members. Every therapy group will develop its own configurations, its peculiar network of interpersonal relationships, roles, and values. Selection and screening is only one item in a long and poorly understood list of variables which influence the development and maintenance of a therapy-fostering group atmosphere. When discussing diagnostic and screening techniques, one must keep in mind that the selection of an individual patient is really meaningful only in relation to the factors of group dynamics in the particular group for which membership is being considered.

In our examples, the two model groups were adults who suffered from mild to severe types of psychosomatic and/or personality disorders. Most of our patients are referred by their physicians, although referrals for intensive group therapy from other sources, especially former patients, are not uncommon. After checking the medical clearance and recommendation for psychotherapy, an entrance interview and a series of psychological tests are given to all referred patients. The need for psychotherapy in general and the suitability for group therapy is ascertained by the established methods of psychodiagnosis.

In the present setting these diagnostic procedures serve three rather different purposes. In the first place, the necessity for psychotherapy or any other kind of psychiatric treatment has to be established. Not every individual referred to psychotherapy requires or could derive help from intensive psychotherapy of any kind. Secondly, when the need for intensive psychological treatment is present, the question must be raised as to what type of intensive approach may be most suitable for the particular patient under consideration. Clinical experience shows that

many patients who have not made significant gains in individual therapy regimes do well in intensive group therapy, and the opposite has also been observed. Thirdly, after a patient is considered suitable for intensive group therapy, the quality of his particular personality problems must be evaluated relative to the psychological atmosphere of the particular group for which the new patient may be selected.

Diagnostic procedures are continued until the severity and quality of psychopathology can be evaluated. Indications of the probability of psychotic breakdown, suicide, lack of impulse control and/or illegal behavior tendencies must be detected. If present, the findings are discussed with a psychiatrist and the base of clinical responsibility is broadened to include the referring physician, the psychiatrist, and the group-therapist. On many occasions the decision of this team may be to consider the patient unsuitable for placement in group psychotherapy. If it is decided that a patient can profit from group therapy participation, the results of the diagnostic study are examined with a new objective in mind: to detect the presence of specific indications relevant to selecting a given patient for placement in a given group.

In our diagnoses we look for certain individual characteristics in the patients which experience has shown are useful indicators as to how an individual will behave in a therapy group. Powdermaker and Frank (1953) have summarized three characteristics which in our own experience as well as in theirs are found to be very relevant to the patients' ability to make good group therapy adjustments. These characteristics are the intensity and quality of the patient's authority problem relative to his ability to adjust to peers; ability to expose so-called weaknesses before a peer group; and ability to express aggressiveness coupled with a fair tolerance for tensions produced by hostile expressions on the part of the self and others toward the self. These characteristics, while important in predicting the successful placement of patients, are, however, not easily ascertained beforehand by ordinary methods. In order to get at least some information on these individual characteristics, we employ in addition to interviews a number of psychological test procedures.

## The Prediction of Group Adjustment

The following psychological tests are always included in our regime: the Rorschach,<sup>1</sup> a sentence completion test, figure drawing, and the MMPI. Some special cases require further diagnostic study, which would include the TAT, the Wechsler-Bellevue, or other diagnostic instruments.

In addition to the established procedures of psychodiagnosis already mentioned above, we are using three original techniques which help to make an estimate of potentiality for good adjustment in the therapy group.

**1. MAPS Figure Grouping.** The first of these assessment techniques involves the MAPS materials (Schneidman, 1949). We ask the patient to sort the MAPS figures into groups. A study of the groupings the patient produces by sorting the various paper figures into different piles on a table provides clues as to the quality and degree of repression of his mutuality need. The sorting often locates fears of opposite sex figures, or status figures, or children. In an "inquiry" we interview the patient about his groupings and ascertain where he may feel he belongs or does not belong. We watch and see whether his groups have the hierarchical power structure of family grouping, or whether the patient tends to assemble associative or peer groupings. What we get from this is a clinical estimate of potential capacity for reciprocal contact relations in the actual therapy group. The sorting manner, form, and speed give some indication of compulsions, level of aspiration, rigidity, and spontaneity. Creative intelligence can also be estimated. Thus, valuable qualitative clues for a better understanding of the results of the standardized diagnostic procedures are provided.

**2. Life Space Drawing.** Kurt Lewin's topological diagrams are well known to students of his *Dynamic Theory of Personality* (1935a). Many college teachers of psychology have found Lewin's method of representing psychological forces in space a very helpful educational device. In diagnosis we have found it

<sup>1</sup> For this specific application of the Rorschach method in grouping patients, see Powdermaker and Frank (1953).



helpful to let the patient tell us the closeness to and distance from others in his actual social environment. After drawing a circle at the center of an ordinary sheet of typing paper containing the initials of the patient, the clinician hands the sheet of paper to the patient with the request: "Think of this white space around the circle containing your initials as your actual social environment. Indicate the people to whom you have to adjust in your daily life. I like to get your own picture of it. Draw more circles with initials in them to indicate who belongs to your environment. You can put the circles close to or farther away from the circle representing your own self to indicate how close to or how distant you feel from these people."

Most patients find it easy to represent their present social field. The patient's social field drawings serve as a basis for an interview in which the patient's actual social adjustment or isolation in his real environment is evaluated. A somewhat different technique, but seeking the same type of information, is the "interpersonal relations interview" devised by Maas and Varon (cf. Powdermaker and Frank, 1953). Our inquiry into the life space drawings invariably reveals that some important persons are left out. The nature of these omissions, while not discussed with the patient at this time, is kept in mind. When traumatic, severely pathogenic histories are revealed, we may ask the patient to draw other life space sections pertaining to earlier phases of his past life.

During the course of therapy we may suggest to a group to draw the life space of interpersonal relations within the group at that time. From these pictures we get a quantifiable estimate of the degree of psychological isolation as experienced by the patient.

**3. Visiting.** The visiting technique permits the new patient to meet other older patients with similar symptoms. These patients are sophisticated "veterans" with experience in group participation. These meetings take place in pairs, or an entire group may meet a potential candidate before or after a group session. The therapist simply introduces by first name, then lets the patients chat with each other. The new patient's reactions to these meetings are diagnostically helpful as an estimate of his contact capacity with these particular group members. The older pa-



tients' reactions to him are also helpful in this respect. Furthermore, their having met the potential newcomer makes group decisions concerning selecting replacements or additions to the group a more meaningful procedure.

The final decision as to which particular patient should be included in or excluded from a particular group follows certain broad lines, rather than being governed by specific test scores. Personality structure data obtainable through test procedures are neither specific enough nor stable enough for the prediction of actual interpersonal behavior in groups. This is because of the interdependent nature of personality structure and the group dynamic situation, a systematic question which will be discussed in a later chapter.

### **Belonging and Not Belonging from a Clinical Standpoint**

The in-group-out-group, or the boundary phenomenon, attracts the professional interest of every group therapist. This interest expresses itself in his concern with selection. Many colleagues believe the success or failure of group therapy depends upon the effective selection and careful screening of individual candidates for group therapy. Faith in the value of screening and selection is often expressed by the idea that "group therapy is like a caravan—it travels at the speed of the slowest member." There is indeed a caravan-like interdependency among members in therapy groups. But the analogy may be misleading unless one can say that the slowest camel tries to stay with the group and not get isolated in the desert. Naturally, before the caravan starts it is wise to make a minimal selection and leave out those who are too sick, too young, or too burdened to walk and carry their share. But there are many factors other than the "slowest individual" which can slow down and even hold up a caravan, factors inherent in the dynamics of herd and group life.

Evidence concerning the psychological interdependency of human organisms makes it clear that it is impossible to predict the behavior of the group reliably on the basis of diagnostic evaluations of the individual members. This is true for the neuroses

and character disorders from which most of the population for intensive psychotherapy is drawn. It is less true for chronic hospitalized psychotic patients, such as catatonics. The faith that adequate selection is a major assurance of therapeutic efficiency in group therapy is consequently bound to remain an unfulfilled, naïve, professional wish. At present we cannot go beyond making a few broad and obvious principles for grouping.

The selection of patients for therapy groups is based on the recognition, gained in clinical practice, of those personality factors which, in a given group situation, tend to complicate group life by increasing the level of anxiety and tension. The objective of such a selection is the avoidance of some obvious sources of excessive tension and anxiety for all participants. Good selection cannot guarantee a healthy group life. This can be gained only through a slow growth of a therapeutic group culture. Effective selection procedures require a distinction between (1) personality criteria, (2) environmental criteria, and (3) group dynamic criteria. Personality criteria for the inclusion or exclusion of a particular patient from participation in intensive group therapy programs include individual behavior idiosyncracies. Environmental criteria refer to the state of realistic difficulties in the actual life situation of patients. Group dynamic criteria refer to characteristics of a particular therapy group at the time a vacancy exists.

#### **Four Personality Criteria for Exclusion**

Accumulated observations from clinical practice permit rough predictions as to which type of personality is unlikely to make significant therapeutic gains through participation in the type of intensive group psychotherapy described in this book.

Through interviews, psychological tests and trial periods of group attendance, the psychotherapist can ascertain whether or not a patient shows certain characteristics which singly or in combination make him unsuitable for group therapy in a private practice setting.

- 1. Insufficient Reality Contact.** Patients are excluded who are unable to follow a relatively rapid type of verbal communica-

tion and shifts in trains of thought. All psychologically disturbed patients have poor perception of self and social reality, but the neurotic patient still attempts to match what Cameron (1951) has called the "pseudo community" with the actual community before him. We exclude, as a rule, the psychotic who has turned away from this attempt to substantiate his illusionary world with the behavior of those surrounding him. So-called prepsychotics or subpsychotics, whose need structures are quite immature or instinctually raw, can be included so long as the ego still functions in its attempt to find realistic gratifications. The boundary line between excluding the psychotic and including the subpsychotic requires considerable clinical study by a diagnostic team.

The exclusion of patients with insufficient reality contact is in the nature of protecting them, rather than the group, from excessive anxiety, for it is remarkable how deeply understanding a group of outpatient neurotics can be toward a psychotic member who was inadvisably placed in such a neurotic group. The experience of being unable to follow the train of thinking of the group reinforces the already strong feelings of isolation which such a psychotic member feels. This is obviously a contraindication for group placement.

**2. Culturally Deviant Symptomatology.** Outpatient and private practice groups are threatened by patients who exhibit extreme examples of culturally tabooed or illegal behavior. While milder instances of illegal symptomatology are perfectly acceptable, the presence of a member with, let us say, a criminal record among a group of highly conscientious, neurotic citizens often presents an insurmountable type of conflict for both sides. We have, therefore, found it necessary to group outpatients with extremely deviant symptomatology together in a homogeneous group of their own.

**3. Dominant Character: the Chronic Monopolist.** The emotional energy of groups can be literally exhausted by the group's need to adjust to the spotlight and other demands of a dominating member. Bion (1948-51) cites the example of whole cultures (such as the pyramid-building epoch of the Egyp-

tians) exhausting themselves in an attempt to pacify dominant, monopolistic individuals. The reaction of the German people to Hitler is another example on a broad sociological plane. Powdermaker and Frank (1953) observed that group tensions are heightened in intensity by what they term "habitual monopolists," that is, patients who become anxiety-ridden when anyone else becomes the focus of attention of the group, and who as a defense against their anxious jealousy are compelled to hold the center of the stage by whatever means they can. To many psychologically unsophisticated patients, as well as to the public at large, overtly monopolistic tendencies that are uncontaminated by manifest signs of destructive hostility tend to signify a strong ego, while clinically and technically the monopolistic tendency is recognized as a defense against anxiety and fear of isolation instigated by the group situation.

The attempt to rule the roost in a group proves a defensive overreaction to neurotically feared attack or isolation from the group. Because of the recognition of the type of motivation behind the habitual monopolist, the chances that such a patient may adjust to any group therapy program are very small. In our own experience during years of group therapy practice we have attempted to place such individuals in various groups, each having different constellations. Yet the monopolistic patients, although consciously desirous of adjusting, were unable to do so. Powdermaker and Frank (1953) report similar experiences of failure in the treatment of monopolistic patients in various groups under the leadership of different psychiatrists, all of whom tried various techniques of adjusting such persons to the group without success. Since many psychosomatic patients—for example, the aggressive business man suffering from psychosomatically influenced peptic ulcer, or the aggressively exhibitionistic actresses—are in need of psychotherapy, it is a technical challenge to find a place for the habitual monopolist in therapy groups.

Such individuals can be very useful therapeutically when placed in a group provided there is always present in the group a pair of fairly advanced, psychologically sophisticated members who are expressive and explicit enough to check the influence of



the dominant, monopolistic newcomer. We have made it a practice to place habitual monopolists in the groups only on a probationary or trial basis. After initial individual contact, and careful psychological screening and study, they are confronted with their monopolistic qualities as shown in their work and family life, as well as in the diagnostic situation. The "probationary" nature of the trial group placement is pointed out to them as a protection against their being emotionally rejected by the group, as well as a method of gearing their attention from the very beginning to a central aspect of their own social-emotional difficulties. Practice has shown that it may at times be necessary to take such patients out of one group for more intensive individual work and then either return them to their initial group or place them in another. If the above precautions are observed, group therapy need not be closed to the large group of character neuroses for which the prognosis in other types of psychotherapy is notoriously poor (Knight, 1949).

**4. Psychopathic Defense and Impulsiveness.** A series of unfortunate experiences with patients who are usually classed under extreme "psychopathic deviation," as shown by their irresponsible life history, their shallowness of affect, and other relatively unmistakable indications, have made it an unexceptional rule in our practice now to select carefully the psychopathic deviant and exclude him from groups of neurotics. Previous to making this rule, psychopaths have been observed in groups to act out their impulses on the other members in very egotistical ways. For example, male psychopaths will sexually excite, mislead and seduce the neurotic women in the group. Psychopathic women will do the same to the male, whose conscience conflicts will be exacerbated by his inability to resist a dovetailing reaction to the psychopath. Another difficulty which we incurred in the earlier days by admitting psychopathic personalities was that at times they could not control their hostile impulses when in the group. When the groups countered, the psychopathic patients responded with their favorite acting-out defense: running away (Bromberg and Franklin, 1952).

Psychopathic personalities fascinate groups because they seem to be able to get away with all the "forbidden pleasures" of life.



Consequently, a neurotic group's attention will be almost completely absorbed by vicarious participation, with reactive judging and rejecting the psychopath's more or less serious deviations from the cultural norm, which is so jealously guarded by the strict conscience of the average neurotic patient. To the neurotic member of the therapy group, the psychopath's impulse-ridden nature, his inability to discriminate conjunctive from disjunctive ways of reducing his need tensions, is frightening. Neurotics often are keenly and sympathetically aware of many psychopaths' fairly obvious need to get themselves destroyed by society. However, the chances that this constructive, sympathetic attitude would prevail over the rejecting ones are so slight that we no longer accept psychopaths for psychotherapy, unless we can see them in an institutional setting. This practice is shared by most group psychotherapists. For example, Slavson (1950a) recommends:

Psychopathic personalities are unsuitable for group treatment . . . patients of this type cannot adjust to group life and interfere with the therapeutic opportunities of the others. The need for object relationships and a striving to change that patients must have in order to make progress in treatment is lacking. Psychopaths, being narcissistic with defective superego formation and little social hunger, exploit the permissive and tolerant attitudes in the group for their egotistic ends to the detriment of fellow members . . . they irritate the group members, who become resentful and attack them. Because of the egotistic nature of this state, the patient cannot tolerate such rejection. . . . Institutionalization is recommended for psychopaths. They require external pressures which a voluntary therapy group cannot provide. . . .<sup>1</sup>

In institutional settings good results from group psychotherapy with psychopathic deviants have been reported by Bromberg and Franklin (1952), and others. Even in our own experience in the private practice setting the more mildly acting-out psychopaths may become valuable group stimuli in the presence of an experienced and realistic therapist. With their rather obvious acting-out patterns, such patients help the other neurotic patients to perceive the reality of the disjunctive interpersonal effects of personality disorder.

<sup>1</sup> Quoted from S. R. Slavson, *Analytic Group Psychotherapy*, by permission of Columbia University Press.

## Environmental Criteria for Exclusion of New Patients

It is the unhappy experience of all psychotherapists that people often wait in their search for psychological rehabilitation until an acute environmental crisis—such as divorce—has occurred or is about to occur. A crisis in the social environment naturally absorbs the attention of the patient involved in it, but this is not the best time to attempt insight. Rather, the patient is “hell-bent” on action, and often these actions are acting-out defenses. All one can do during such a period is to give the patient some support and perhaps help him to see the immediate problem in a wider past and future perspective. Placement in an intensive group at such a time is definitely contraindicated.

Experience has shown that therapy groups strongly identify with an emergency; they like to get into the act even though they realistically know they cannot. Since the group can do no better than either the therapist or the patient as far as changing or removing the environmental conflict is concerned, the preoccupation of the group with acute environmental emergencies always leads to a feeling of frustration over the inability realistically to “do something.” This, in turn, leads to increased group tension and finally to hostility. The latter, while usually released on the therapist-catalyst, is actually intended for the patient who brought up this emergency. From the viewpoint of the patient, the group’s initial interest and identification with the patient’s problem raises his hope for effective help and assistance from the group. When the patient discovers that the group is realistically helpless he feels let down by the group and becomes, himself, hostile first to the therapist and then to other members of the group. In spite of needing psychotherapy badly, patients must leave a group after experiencing this type of “being let down.”

Another reason for excluding patients under acute environmental stress from group treatment is that the reporting of environmental goings on detracts the group’s attention from the here-and-now interpersonal relationships. This is, in intensive group therapy, a fundamental objection to the inclusion of such patients. The effectiveness of the group medium lies in the de-

gree to which patients can get interested in the details of emotional feelings about each other in the group. Such an attitude is not easy to achieve, even when environmental stresses are not acute. It is naturally easier to discuss relationships and conflicts with parents, husbands, co-workers, bosses and lovers than to discuss intimate interpersonal feelings evoked by the here-and-now present strangers with whom a member is brought in contact in a therapy group. Emergency situations stimulate the reporting of out-of-group goings on. This in turn may reinforce the patient's natural escape from coming to terms with his here and now emotional interdependence.

The fact that wrestling with reports on acute environmental emergencies is therapeutically unproductive, is a very unpopular limitation of psychotherapy. Psychotherapy does not constitute an immediate remedy for the sufferers of stress situations. In fact, it must appear paradoxical to the public, to new patients and often even to the medical referring sources that the content of communications in intensive psychotherapy quickly leaves the subject of referral, which usually is some acute stress situation or symptom. Only our therapeutic failures continue to stay on the subject of the stress which initiated their entry into a psychotherapy program.

Since all patients referred to psychotherapy are under some sort of acute emergency or stress, one should select those patients in whom one can detect in the diagnostic interviews the capacity for insight into their own contribution to the acute environmental stress situation. Only those individuals are rejected from group placement whom the clinician feels will not in due time give up their displacement defenses. By the same token, one can safely include those who are already curious about their own part in a stress situation or who seem to understand easily an explanation of the detour-nature of psychotherapy.

It goes without saying that patients who actually are confronted with a stressing reality problem, as when a parent discovers that his child is constitutionally defective, must be distinguished from neurotic and psychotic sufferers. The latter's emergencies are symptomatic of an ingrained defense of projection and displacement, while the former patient's anxiety mirrors



an unsuccessful attempt to master a realistically difficult situation. When realistic emergencies threaten the individual, psychological guidance and support can be a very constructive service. Such supportive guidance includes in our practice the placing of patients with similar realistic emergencies in a limited group therapy program, through which the members can pool their resources and provide support for each other.

### Group Dynamic Criteria for Selection

Relative to the field of personality dynamics, too little is known today about the dynamic structure and social psychology of small groups to provide many practical principles of therapy group development. The few tentative suggestions that can be made in this direction at present will be discussed in the theoretical sections of this book. Criteria of group dynamics governing the selection of one or two newcomers or replacements for therapy in a relatively stable group will differ widely, depending on what kind of roles are open in a particular group at a particular time. One group may at a certain time have an opening for an aggressive male, while another group would reject such an individual, seeking instead to add to the team a passive-dependent female patient. One group can safely absorb a newcomer who is extremely disturbed while another group would ask only a mild anxiety neurotic to join it. In our regime, the group of patients who belong at the time of selection actively participate in gauging the nature of the group dynamic state of affairs. Thus, selection is made not only with respect to clinical personality considerations, but selection procedures take cognizance of the need of the group to increase its role repertoire, in order to obtain better complementation between roles. In searching for criteria for composing optimum therapeutic grouping of chronic schizophrenic patients, Powdermaker and Frank (1953) paid attention to the compatibility of various patients' habitual "group role" with the role patterns shown by other members and by the therapist.

A second group dynamic criterion, in addition to "role opening," is the prevention of isolated subgrouping. Initial adjust-

ment to the group is a very difficult phase for the new entrant who at first feels isolated. This initial isolation may remain fixed, thus interfering with the smooth functioning of the therapy group. To prevent such a fixation of initial isolation, one should try to place only individuals who, from some reference point important to them, say the symptom, the social class, religion, or the like, can find in the existing group at least one other who initially appears similar to them.

Some therapists try to group patients according to homogeneity with respect to certain psychiatric or social criteria. In our sample regime this was not done. Because we wish to widen the experiential horizon of our patients, our groups seek a more heterogeneous membership. They prefer, for example, mixed-sex to one-sex groups. They prefer a large age range, and a fair range in social and economic status. Our policy of heterogeneous placement of patients is in line with the clinical experiences reported by Powdermaker and Frank (1953), who found it helpful in their Veterans Administration Mental Hygiene Clinic Program to place patients in the same group who showed great individual differences with respect to clinical diagnoses, educational level, race, religion, cultural background, economic class, age, and extent of life experience.

The principle of heterogeneity, however, can be overdone and misapplied. For example, with respect to the age range, we find it necessary to exclude very young adults with little sexual and social experience from more experienced adult groups. While we definitely like to mix married and unmarried members in the same group, we see to it that we have at least two of each category in the same group. In general, we limit excessive heterogeneity by trying to place a patient in a group where he can find at least one other patient in circumstances which are similar with respect to some central phase of his own life. The application of the three personality criteria for exclusion given above naturally lead to conservatism in the application of the principle of heterogeneity. The principle of providing each member with a matching member in some respects further limits unselective heterogeneity.



There is one dimension along which we have found it necessary to make a special grouping, and this has to do with the factor of intelligence. In view of the relative newness of psychotherapy, physicians in private practice tend to refer only relatively educated people of above average intelligence. As psychotherapy becomes more and more acceptable as a general practice, however, more and more patients from the less educated and/or less intelligent classes are referred. If such patients are placed in groups predominated by the more verbally fluent, better educated individuals, they have been observed to feel out of place. Careful attention to the factor of verbal fluency in the case of relatively uneducated or relatively less intelligent persons helps to offset mistakes in placement in this respect.

At present the understanding of selection cannot go much beyond the relatively broad criteria given above. As research in psychotherapeutic techniques begins to produce more specific measurements, we can look forward to more systematic ways of selecting patients for therapy groups. The present limitations of knowledge concerning effective and detailed selection procedures should not be too discouraging to prospective group therapists. It must be remembered at all times that, even with the best possible selection procedures, one cannot regulate the dynamics of the group life by these procedures. In fact, it is reasonable to hypothesize that every group will make the best possible use of its personnel. In other words, while there is no question that certain personality and sociological characteristics of individual members make a great difference, every group nevertheless develops a characteristic life. In this life the group makes room for whatever personality idiosyncrasies may be demonstrated within its boundary. Consequently, careful selection does not, by any means, fulfill the clinical task of the therapist. He must pay continuous attention to those processes in the group that, according to his perception of the therapeutic process, facilitate, rather than retard, the rehabilitating effects of the group on individuals suffering from psychological stress.

## Chapter 3

### PREPARATION AND INTRODUCTION OF NEW PATIENTS

---

Psychotherapists practicing individual methods are surprised to note how relatively little resistance the average patient in intensive therapy groups shows to sharing his difficulties with other patients. Actually, a cultural rather than the more narrow clinical concern would lead one to expect the acceptance of the group therapy idea, for the American scene is characterized by a general tendency toward communal life and toward evaluating one's actions in the light of reactions by others (Mead, 1951; Riesman, 1950). The emphasis on individual competitive success and personal acquisition represses the full development of mutuality. Consequently, when the individual in such a culture is provided with an opportunity where it is safe to express helpfulness, neighborliness and mutual aid without loss of individual gain, he is likely to avail himself of such an opportunity. At least this is one explanation of why group psychotherapy is actively sought by increasing numbers of patients. Those who show strong initial resistance to group therapy invariably belong to one of two groups: patients who are afraid of groups, and patients who are afraid to lose the therapist's exclusive attention.

As far as the patient who fears groups is concerned, we most likely have to deal with a symptom of psychopathology expressed in psychological isolation. If we can learn a lesson from the success of the concentrated type of individual attention that recently has been given the chronic, hospitalized, regressed catatonics, the suggestion arises that for patients with strong social phobias intensive individual attention may be a necessary bridge to group placement. In such cases it has been found helpful gradually to introduce these severely isolated patients to

the idea of sharing the therapist by having another one or two patients join in the individual sessions. The majority of neurotic patients are not frightened of grouping. Few have overt fears of social contact. Most of them function quite successfully in social settings, at least in the business world. The trouble lies on the level of intimate interpersonal relations such as are required in marriage and family life.

### Steps in the Preparation of the New Patient

The first step in the preparation of the patient is a brief summary and interpretation of the results of the diagnostic tests taken by the patient. The fact that studies were made to determine the patient's suitability for group placement seems to reinforce in the patient the wish to become part of a group.

For the optimal success of a group therapy program, a choice of several groups should be available through the coordinated efforts of several therapists, for the next step in the preparation involves a reaction to the invariable curiosity of the patient about what these groups are like. We have found it clinically helpful to involve the patient in the decision as to what group he would feel most adequate in. Usually patients ask for a brief case history of a group meeting. In response to this request, we may permit the patients to read typed protocols of group meetings and/or listen to old wire recordings. These are the same types of records that we use for seminar demonstrations for professional-educational purposes.

Next, the patient is handed a typewritten preparation sheet on which six procedural principles, which determine the conditions under which he accepts group therapy membership, are written as follows:

#### Group Therapy Procedures

##### *Preparation Sheet for New Patients*

1. *Size of group.* The group's size is limited to a minimum number of six and a maximum number of ten patients.
2. *Admission of new members.* When an old member leaves the group his or her place in the group will be filled by a new patient.

The selection is made by group decision, from several candidates considered suitable for group therapy by the therapist.

3. *Extraoffice meetings.* The regular office meetings of the group with the therapist, while of central therapeutic importance, are only part of the total program. Experiences during the post-session and during any other out-of-the-office contacts between members of the group, provide important material for self-observation and analysis.

4. *Sharing of mutual experiences.* Group members usually adhere to the principle that everything anybody says, thinks or does, which involves another member of the group, is subject to open discussion in the group. In other words, the emotionally important experiences of any member are shared by all members. There are no secrets *inside* the group.

5. *Ethical confidence.* In contrast to Principle No. 4, everything that goes on within the group—everything (!)—must remain an absolute *secret* as far as any outsider (nonmember) is concerned. The only exceptions are professional visitors, scientific observers, and/or psychiatric consultants and assistants who may help the therapist's professional work with groups. Anyone participating in group therapy automatically assumes the same professional ethics of *absolute discretion* which bind professional therapists.

6. *The group's goal.* The *group goal* is free communication on a nondefensive, personal and emotional level. This goal can be reached only by the group effort. Experience shows that the official conductor cannot "push" the group; the group has to progress by its own efforts. Each member will get out of the group what he puts into it. As every member communicates to the group his feelings and perceptions and associations of the moment as openly as he can and as often as he can, the group will become a therapeutically effective medium.

After the patient is thus given an opportunity to have as realistic an anticipation of the group as possible, he usually is not interested in further details, but assumes the attitude of wanting to see for himself. Clinically, we now consider the patient ready for group placement. Practically speaking, however, a suitable opening may not be available at this time. On occasion it is necessary to continue individual contact for as long as five months before an appropriate placement can be made. Even if openings are available, because of the group's participation in the



selection of their own members, certain patients may not be chosen for some time.

The preparation of the patient is mediated primarily through an attitude on the part of the therapist, namely, his sincere conviction that the group life experience, more than any other aspect of the therapy, is of crucial importance to the patient's rehabilitation. In view of the fact that patients in their transference attitude unconsciously dovetail their own frame of reference with that of the therapist, the value reference of the therapist results in a comparable manifestation of interest and often even eagerness to join the group on the part of the patient. It goes without saying that when a therapist suggests to a patient the idea of group participation in a halfhearted or even skeptical manner, the patient's resistive response to group therapy reflects an ambivalent or even a negative attitude toward group therapy, which is not uncommon among therapists trained in the individual psychoanalytic tradition (cf. Powdermaker and Frank, 1953).

### Introduction of the New Patient to the Group

Once the group has selected a new patient, the time for his joining the group is announced by the therapist in advance. Part of the session preceding the arrival of the new member is devoted, by suggestion from the therapist, to a short discussion of how it felt to come to the group for the first time. Such retrospections reveal that there was (now it can be told) very serious anxiety and tension behind the overt curiosity and agreement to come. The therapist simply reflects upon this fact, and the group quickly perceives the idea that they will have to "take it easy" with the newcomer and let him find his own place in the group without being pushed into it. Such a preparatory group ritual may not be necessary in a very sophisticated group.

Newcomers unfortunately have a need to confess whatever they feel is wrong with them or shameful about their lives, even though they have been explicitly told in their preparation that there is no need to make an effort to "tell everything" during the first few meetings. All members of a group will get to know each other very well.

## Newcomers' Reactions to the First Group Meeting

The established nucleus of a therapy group can be relied on to show a tactful and protective attitude toward a newcomer. A group can become so considerate of a newcomer's initial anxiety that they permit him or her to talk during the entire session. In one such case everyone recognized that the newcomer was terribly frightened, and that her way of living through the first meeting was to talk her way through it.

We make it a rule to schedule an individual interview a day or two following the first group therapy experience of any patient. Following this first group meeting the new patient is usually full of impressions which he is eager to share with someone. Some patients make notes about their feelings, of which the following protocol is an example. In this protocol the therapist is referred to as "George," which is a reflection of the general habit of using only first names in therapy groups. The patient read her notes in the next group meeting.

### PROTOCOL NO. 1: A NEW PATIENT'S REACTIONS TO HER FIRST GROUP THERAPY SESSION

My immediate reaction was not as disturbing as I had anticipated. I was able to speak fairly freely but was confused in my thoughts. I felt that my mind worked faster than my speech and that the final expression sounded disjointed.

The idea of "going around" and getting reaction from group members is a two-fold problem for me. One is that it threatens me, knowing that I have to speak and at the same time it hinders me from completely listening to what the others are saying as I am trying to collect my own thoughts so I can speak when my turn comes. The other problem is that it forces me to speak when I wish that it could be spontaneous, although at the same time I realize that this is a beginning to future spontaneity. . . .

Z-F threatened me the most, both in the group and in the post-session. She gave me the feeling that she possessed superior intellect in respect to the rest of the group. Only at one time did I feel nearly equal to her and that was when she reacted so quickly to Y-F's use of the term "ill." I felt myself laughing inside because

she could not accept the fact that there was something basic about her that needed attention. I wanted to express this but did not. I felt rebellious toward her in the post-session when she began explaining to me the meaning of various words. Here I had the feeling that she was explaining something to a child who did not understand a difficult situation.

Y-F and X-M gave a settled feeling to the group, I imagine because of my knowledge of their previous group experience. At the same time I was very much surprised at Y's reluctance to speak freely on her sex problem.

W-M bothered me in the respect that he talked too much, to the extent that I found myself not listening to him. On reading the group report [a transcription of the wire recording of the first meeting] this morning on which W had expressed himself, I found it to be repetitious and it backed my feelings on his talking at great length.

Y-F bothered me several times when she was explaining the procedure and such to the group. She would look directly at me when she talked. I projected the feeling that I was again a child and she wanted to be sure that I understood everything she said. I definitely resented this. This brings out one of my problems on how I feel people react toward me. I have the feeling that people think of me as a sweet innocent little girl who needs guidance. As a matter of fact these adjectives have been applied to me more than once. This makes me wonder if my behavior demands or "draws" this type of reaction.

George threatened me several times when he called on me to speak or when I anticipated that he was going to call on me. I was also anxious to hear his reaction to the group as a whole and to the individuals and their participation in it. Reflecting on my feelings at the time I wondered why I was so anxious to hear what George had to say and hoped it would confirm my feelings that the group was doing well. My first association was "Did we do well, Daddy?" This brought to my mind the need for father approval.

In the post-session I did not feel a part of the group. X-M monopolized my time by talking to me. My desire to feel a part of the group was so great that I found myself several times not listening to him, then deliberately forcing myself to listen. I felt that he held me back from becoming better acquainted with the other members, although at the same time I did nothing about it.

My feeling on presenting this to the group is one of fear, not only in having to read it but also any reactions that might be caused by it.

In the individual session at which the above report was read to and discussed by the group, the patient noticed a feeling of disloyalty in talking to the therapist about the other members. This is an early sign of group identification. When the therapist suggested that it was up to her to let the group share in feelings of "disloyalty," she was a little afraid, but she brought this report to the group, starting the next meeting by reading it to them. This was very stimulating and started a lively discussion which helped to integrate this new member into the group.

### Therapeutic Effects of Continuous Grouping

Replacing graduating members with new patients, and individual differences among patients in intensity of disorder as well as the duration of continuous attendance are two variables responsible for the simultaneous presence, in the therapy group, of patients who are communicating on different levels of intercourse. The fact that different patients have reached different levels of therapy gains facilitates the gauging of therapeutic progress. Older patients can differentiate the stage which they have reached from an earlier one by comparing their own behavior with the type of participation shown by the newer and/or more severely disturbed and slower moving patients.

Established groups at times will express resistance by not voting for new members. There is a feeling, not infrequently shared by inexperienced group therapists (cf. Powdermaker and Frank, 1953) that newcomers would seriously retard the therapeutic progress of the group, that time and energy would be unconstructively spent in a difficult attempt to pull the new member up to the level of communication that an advanced group has reached. These fears of the old members of a group are not quite justified. In the first place, many newcomers quickly learn to identify with the prevailing group level of discourse. This is a decided advantage of the continuous method of grouping over the method of closed grouping. New members in a way shortcut their defensiveness by identifying with the other members who have already overcome their defensiveness. In the second place, the presence of less "advanced" group members has ego-strength-



ening effects on the older members, who therapeutically gain by the experience of helping new patients to adjust to the group.

After the new patient has survived the second meeting, there is usually no further problem of preparation or introduction. Now the newcomer is on his own, even though he may not feel it at all himself. The group therapist can usually rely on the patient's maintaining his group membership until he feels he has made gains significant to himself. One of the remarkable and clear-cut advantages of the group method is that the problem of resistance hardly ever expresses itself in a primitive refusal to talk or to stay away from the therapy sessions.

Once introduction and preparation has succeeded in overcoming the initial resistances of new patients against participation in the therapy group, once the newcomer has had the opportunity to taste the empathetic acceptance of his fellows and peers, his attitude changes from defence against the group to becoming a good group member. Only 5 to 10 per cent of the new patients find it impossible to adjust to their first group after overcoming initial resistance. Even most of these eventually work themselves into a good group adjustment after shifting from one particular group to another (cf. Wolf, 1949-50).

## Chapter 4

### MANAGEMENT OF EARLY RESISTANCE

---

The successful formation and development of a therapeutically functioning new group can be delayed and endangered by certain, rationally paradoxical, resistance attitudes on the part of new patients. Early resistances seem to be a reflection of the peculiar quality of the psychological field forces existing in as yet unstructured groups. Since in this early phase of treatment the patient's ego has not yet been touched by the therapy, this early form of resistance cannot be interpreted as the ego-defensive maneuvers of resistance occurring in later phases of treatment (cf. Chapter 17).

While the overt forms of early and later resistance behavior are quite similar, expressing themselves, for example, in the same attempt to weaken or to destroy the group, the covert or latent motives behind early and later resistance are very different. Later resistance is motivated by the need for ego defenses. Early resistance is motivated by the individual's problems of emotional adjustment to a novel and unstructured situation. Anticipatory anxiety, expectation of authoritative leadership, and other preliminary attitudes seem to be responsible for early resistance. The therapist can help the group to work through the early resistance phase faster if he fully observes the group members' struggles with sources of anxiety and tension which are typically present in early phases of group life.

**Anticipatory Anxiety.** The anticipatory anxiety over the first group meeting was briefly referred to in a previous chapter. All patients and many group therapists are somewhat anxious about the first meeting of a new group. The existence of this anxiety assures the success of the first meeting. After being together for twenty minutes, everyone discovers that whatever

the vague fears were, they seem to be unjustified. Relaxation and interest take the place of anxiety. Relief of anticipatory anxiety is a great "morale-raiser." Every first group meeting is invariably a great success. Since the first meeting is consumed with alleviation of anticipatory anxiety, it follows that content of communication is basically secondary to the emotional experience of extinguishing anxiety. These emotional dynamics of the very first meeting of a newly formed group illustrate a basic principle of group psychotherapy: Content of verbal communication is of secondary importance. The quality of emotional experience afforded to the participants is the main focus of interest for the therapist.

Patients may at a first meeting discuss the different reasons that brought each into psychotherapy. Or, in another group, they may immediately seek some common ground and all agree on some attitude or value. The latter was the case in the author's most recently started luncheon group of young mothers, who during the first meeting all comforted each other in sharing the humorously illogical opinion that "men do not make good fathers." It does not matter what the patients discuss. The content of conversation may range from bad fathers, to symptoms, to political issues, or what not. The important point of reference for the therapist is always to recognize the nature of the latent conflict or motivation that finds some relief in any given meeting.

### **Therapist's Role with Respect to Initial Group Tensions**

From the practical view of clinical management, it is important that the conductor or leader be one of the first to recognize and give expression to his recognition of the nature of the early conflicts for which a new group tries to find a solution and relief. By expressing an understanding of the latent conflicts which are present in the early phases of group formation, the therapist helps both himself and others to overcome anxiety. If, for example, a therapist in the first meeting responds to the latent anxiety of the group about this first meeting by becoming directive and didactic about group therapy, or by explaining rules, he should

be able to interpret his own role behavior as reflecting his own, as well as the group's anxiety over being as yet in an "unstructured" state. If he fails to give such an interpretation, he will have lost considerable ground if later on he would like to think of his group therapy program as group-centered, rather than leader-centered. Directive emphasis on the part of the group therapist on having patients discuss "relevant material" is an expression of his own unconscious anxiety over failing to understand what is going on emotionally and interpersonally in the group.

A technique described by Foulkes (1951a) as a method of "leadership by default" is perhaps most appropriate in the initial ten to twenty meetings. It works this way: It is natural in the beginning that patients direct their comments to the therapist. Also, it is natural that emotionally these comments are "authority ridden." Frequently they are in the form of questions for information, which reflect the patient's wish to depend and to be led. In the leader-by-default technique one simply invites the patient to give his own answer by a warm but firm counter invitation: "Let me hear what *you* think about this question." Thus, the therapist, through his own initiatory act of not using his leadership position in a directive or didactic way, gives behavioral notice that the group has to handle its own problems. In our example regime this attitude is not maintained in the rigid form suggested by Foulkes beyond the first twenty meetings, during which, however, it is rigidly maintained in order to carry the impact of an initiatory act. This "defaulting" role carries this message to the group through action, rather than words: "I am throwing your dependency needs back to you. I, the therapist, refuse to fulfill your assumptions that I will or can lead you into mental health via the road of dependency."

### Latent Group Tension and Resistance

The structural frame of reference within which psychotherapists usually understand "resistance" to therapy does not permit a full understanding of "resistance" phenomena in group therapy. In individual psychoanalytic therapy the distinction is made be-



tween defensive resistance, resulting from touching on inner conflicts, and transference resistance (transference neurosis), resulting from the failure of the therapist actually to behave in accordance with the patient's needs to have and to engage fully in transference experiences. In the group therapy setting several factors, in addition to inner conflict and transference, seem to operate, for which the label *group tensions* suggests itself.

Some degree of group tension is an inevitable aspect; it is, in fact, an identifying cue that there is interpersonal contact and interdependence and that a human group is emotionally functioning. It is helpful to apply what Lewin (Lippitt & White, 1947) has called "group atmospheres" and what Redl (1942) and Bion (1948-51) call group emotions or group tensions. Tension can be defined as a need or drive in a state of deprivation, lack of release, or frustration. Group tension is the simultaneous presence of a frustrated state of need in the majority of group members. That is, statements about the presence or absence or degree of group tension are "posits" (Reichenbach, 1951) based on inferences from actual behavior, rather than on phenotypic observations. As noted by Bion, group tensions are mostly latent phenomena that underlie the surface content of the group's communications. We postulate the existence of certain tensions during this initial phase of intensive group therapy and, furthermore, hypothesize on the basis of our observation and experience the relationships between degree of group tension, group activity, and the therapist's role. Our concern is first with identifying the nature of the latent group tensions that are characteristic for the first twelve to fifteen meetings.

### Initial Group Tensions Due to Social Fear and Leader Dependence

Leader-behavior is here defined as the total of all actions and communications by any member of the group (including patients and therapist) that is of an other-directing or other-supporting or other-evaluating nature. Leader behavior permits or sets up a release of dependency needs on the part of those on the receiving end of the other-directing or other-judging or other-supporting

type of interpersonal contact operation. In newly formed groups, latent social fear (fear of rejection, isolation, and the like) and the emotional need for dependency come to a simultaneous peak during the first few sessions, usually the sixth or seventh group meeting. At that point, a difficult crisis, anxiety and resistance become intensified. The nature of this crisis, during which resistance is at a peak, may be described as follows:

The quality of group tension during the first few meetings is strongly influenced by the degree of social fear present. This is why brief group therapy programs cannot go much beyond a sort of psychological servo-mechanism which accomplishes little beyond discharging the anxiety produced by the meetings. The possibility of checking the illusionary nature of social fear by establishing a free atmosphere during the first few meetings quickly reduces the degree of group tension, responsible for the need to express mutuality without fear of rejection or isolation. During these early sessions the group maintains the illusion of directive leadership on the part of the therapist, an illusion which is in constant flux and which any group will try to reinforce.

The group need to find in leader-behavior a release of its insecurities can serve as an explanation for the peculiar fascination and excitement that persons who show leader-behavior instigate in groups. One can always tell the novice, or the insufficiently trained, or the neurotic group therapist by the characteristic of his being unable to resist the group-originating pressure upon him to behave in a "leading" manner. The essence of the art of group therapy technique as far as the therapist's role is concerned is very closely related to the balance that a group therapist can find, at any moment during the continuously fluctuating group life, between fulfilling some of the expectations of the group concerning his leadership, and yet effectively weaning the group from unconstructive dependency.

Since in the first session the official conductor realistically functions as introducer, rallying point, and host, the patients unfortunately feel reinforced in their assumption that he will continue to exhibit leader behavior suitable for the reduction of dependency needs. This anticipation of the patient for the leader to behave in a leading way is motivated by the patient's wish that

he may have a dovetailing reaction of dependency at first, and perhaps revolt later. This group need is so strong that the structuring of the therapy group as "group-centered" appears at this point utterly ineffective. The patients are totally unimpressed with the idea of "group-centeredness," although they intellectually agree to it, and consciously like the idea of a "democratic group." But the deeper emotional need, alas, is to lean, to depend, to set up, and then to fight authority! It usually does not dawn upon the new group until the first six to ten meetings are over that their basic assumption that the therapist will provide leaning opportunities will be frustrated.

The discovery of the defaulting technique of the therapist inevitably leads to an extremely high level of tension. The basic frustration is not the lack of a hoped for release from dependency needs. The basic frustration is the experience of being prevented, by the therapist's defaulting, from setting him up to play a role suitable for acting out those frustrated, and now fixated neurotic motivations, which require some appropriate role-playing on the part of an authoritative contact partner. Thus one type of resistance in group therapy, as in intensive individual psychotherapy, is an expression of the patient's transference needs.

There is no agreement among group therapists as to how this transference resistance is to be resolved. The psychoanalyst Bion (1948-51) has suggested, and the author agrees with him, that transference resistance is usually resolved by a group by finding some patient (usually a paranoid) willing, but hardly able, to fill leader-behavior roles. And this, of course, can lead only to further frustration and hostility; the group's own resolution of its dependency tensions therefore always turns out to be a pseudo solution.

### Degree of Therapist's Active Leadership

In our technique we try to play several roles. We attempt to supply some of the dependency needs at an early point in group formation by playing the following procedural roles in the group: (1) reflection of group-originated communications with simplification and consequent facilitation of understandability of



messages; (2) summarizing and mildly interpreting fairly manifest group emotions as shown by the following protocol; (3) willingness to function as an expert who may introduce a group to such techniques as psychodrama, dream association, projective drawing, and the like.

With this role procedure, we believe that we have given in to the group's need to be led to the extent that we reduce some of the tension and hostility, which from a clinical standpoint are not conducive to therapeutic effects. Resistance in turn generates and revives social fear. It is important to make some gesture toward the prevention of a state by which a therapy group may be concerned for months in trying to find suitable release from a certain amount of dependency tension. For such purposes paranoid leader-volunteers are always ready to serve. We shall discuss these matters further in Part III, where the pros and cons of suggesting programmatic activities are examined both from a clinical and group dynamic standpoint.

Therapists new to the group method are invariably puzzled by the "paradoxical" resistance of patients, paradoxical in view of regular attendance and explicit statements of liking the group. When it is realized that patients like to, because they need to, act out transference tendencies the so-called "paradox" is less puzzling.

Once a group therapist has steered beyond the nineteenth or twentieth meeting without having yielded to the two favorite ways of the group to solve their transference problems, namely, (1) to have the therapist lead, or (2) to have *any* neurotic lead, he has launched his group on its way. Throughout the life of the therapy group much will depend on the artful clinical management of the group's method of acting out transference problems, for example, trying to get around working through their dependency problems during the early phases of group formation.

We have said that during these first few meetings the therapist may take some active part and show leader-behavior in the form of taking notes and summarizing. The following protocol illustrates the procedural leader technique of making a summary. As can be seen, patients express their feelings of relief at seeing



the therapist "do something" in the way of manifesting *some* leading behavior.

PROTOCOL NO. 2: THERAPIST'S FIRST ACTIVE  
PARTICIPATION—SUMMARIZING  
GROUP EMOTIONS

*(At end of the 6th meeting of a newly formed group)*

Therapist: We had several emotions here tonight. First, we started off with the emotions of those who were here early. Those who came early did not like to be kept waiting. Then we also had the emotion that we don't like to talk behind the peoples' backs who are not here. Then, I think we were consumed for awhile with our dominant member's, W's, problems. This was partly due to A's concern with the emergency of his situation and the group was passively listening to the discourse between him and A. Next, we were concerned with the treatment of wives, of how we treat our wives and how wives should be better treated. And then we talked about symptoms a lot, about definitions of impotency, orgasm, fertility, and you pooled your information on that. And then we talked about an emotion of resistance to group therapy by bringing in the public's, as well as a medical doctor's, reaction to it. That led to a discussion, how we each react to a problem of dependency on a boss or authority, and we noticed that the males have the more combative, assertive attitude, and the women here are more submissive, yet hostile. At that point I made the comment that this dependency need is coming out here and now in this group meeting. Then, finally, you discussed supression of anxiety, avoidance of tension, and I noticed that each member here sees the problems of the other members in the light of his own problems. Now, I feel that I left out some emotions. What about this?

[Silence]

X-M: I liked it. I liked your way of summarizing the meeting.

W-M: That was the best part of the program.

[Laughter]

Th.: It feels comfortable to have someone do the work, and sit back and listen to what happens.

W-M: Especially me.

X-M: It's interesting to go back over it like that.

Y-F: I was going to say that it covered very well what we discussed this evening.

Th.: Everyone seems to like these summaries.

X-M: I do.

Y-F (to Th.): It makes one think you were going to do some **work** tonight anyway.

Th.: This way you have some evidence that I do some work.

[Loud laughter]

Th.: That seems to be a popular emotion here. My doing work or not working. Y started it off very well. Now let's have some more reactions to that, about my doing work in the group. How about that? [Smiles]

Z-F: At the beginning I often wondered . . . all these notes . . . private sessions . . . what you do with them. I just wondered if you read them.

Th.: Wondering whether I read them or did what with them?

Z-F: I was wondering whether you read them over. . . . You brought up statements that I mentioned before so that either you remembered all the time or went over it later.

Th.: Is that the work I do, you feel? I read notes and try to memorize some of them?

Z-F: You seem to accumulate everything I mention, even when you do not take any notes.

[Note how the patient tries to set the therapist up as an omnipotent authority figure!]

Th.: How do you like it when I don't take notes?

Z-F: It doesn't make any difference to me because I feel you sense and remember everything.

Th.: Well, Y-F prefers to see that I do a little work here, don't you?

[Laughter]

Y-F: Yes.

V-M (to Th.): Your role, whatever it is, is your business, and if you felt you wanted to take notes for something in particular . . .

Th.: It's up to me, any way I like it. I can do anything I like. How do you like my role, so far?

V-M: So far, I think it's very good. If this is your particular interest, group therapy, it's just the way you want to do some particular thing.

Th.: And you like it. I admit I like it. You accept it. I'm the boss and the way I do it is fine with you.

X-M: I'm only surprised you haven't taken more notes. I went on the assumption that you must retain a lot, because you're writing books and you're using individuals.

Th.: I'm taking notes for my books, for my research, for my own interest?

X-M: No.

V-M: More or less, yes. It has to be your interest. You can't have the same kind of interest for everyone. There must be a deeper motive behind it.

Th.: You mean for every one patient?

V-M: There must be a deeper motive. You have a deeper drive for the whole group.

Th.: Beyond your welfare, I'm interested. Writing books for my own glory, for example.

V-M: No, not glory.

W-M: Profit.

[Explosive laughter]

X-M (laughing): I said that you retained quite a bit of it. The retention bothers me, the problem of intellectualism about it. This you know. I'm upset by people who are so smart because I don't think I am.

Th.: How do you feel right now, sitting here with us, right now? You think I was smarter than you in this meeting today?

X-M: Well, not necessarily. Your retaining power is just one aspect of intellect, I think.

Y-F: He's showing you right now he doesn't retain. He's taking notes.

Th. (to X-M): Y-F is warning you not to overestimate me.

[Laughter]

It is fairly clear from the above protocol that even in this brief action of a new group, there were several latent emotional undercurrents. In the first place, there is unmistakable resentment against the therapist. The overt stimulus for this resentment is his apparent aloofness, his scientific rather than his personal interest. This may be an expression of a deeper underlying resentment against the authority figure not "doing his job" of giving support, of dominating, guiding, and advising.

It is also fairly clear that the patients felt relieved when the therapist did "do a little work," such as giving a summary. It is

important for the therapist to be aware of these group tensions and their relief, even though he may not wish to make an interpretation of them until the group is better established. As in individual therapy, premature interpretations of latent emotions serve only to inhibit their further expression and manifestation. Furthermore, there is such a thing as gradual insight on the part of the group into its own emotional life. This insight may occur spontaneously. Interpretations may actually hinder, rather than foster the perception by the group of its own underlying emotions of dependency, fear, hostility, flight, and pairing, that is, the kind of unconscious group elements that have been described by Bion (1948-51).

For the group therapist who is primarily interested in these group dynamic manifestations, it is, however, almost impossible to refrain from expressing the results of his perceptual focusing. Invariably, the specialized perceptual focusing of a therapist on a certain aspect of group life produces communications from him that fall flat on the group. This does not prove that a scientific observer's feeling for a group emotional process is invalid. Sensitive perceptions of group emotions are not frequently shared by the patients because the patients, while participating in these group emotions, focus their perceptual acuity not on the group emotions but on the emotions of a particular member. In the case of the most advanced patients, this includes to some extent focusing on their own emotions. I think that by and large it is fair to say that the scientifically oriented group therapist is the only person in a group therapy session who has the slightest interest in perceiving the commonly shared group emotions.

### **The New Group's Search for a Goal Structure**

All new groups have their own growing pains while working to give up the temptation to act out their authority problems. It goes without saying that with a directive therapist, groups would not experience this type of growing pains; neither would they be given an early chance to recognize their authority problems. These growing pains are manifested by dull sessions, long silences, by feelings of embarrassment, and failure to release ten-



sion on the part of most members. This phase is maintained unless, as the patients express it, "something happens" to change it. It is in this low-morale phase of the life of a new therapy group that the dominant members "help out" by entertaining the group, but the group is not happy with this either. What actually happens is that, having overcome the initial anxiety of meeting each other, and having enjoyed overcoming this anxiety, they now need new directions. In this transitional phase they naturally feel low in morale, when the official leader conducts the group by default of leadership. It is all very well to interpret this to the group, but an interpretation still does not alter the dynamic fact that the group has as yet no goal structure. It is at this point that in our technique we part company from Bion (1948-51) and Ezriel (1950*b*, 1952) and resume some role of responsibility for leadership as mentioned above.

Therapy group leadership can be described in terms of three different functions: procedural, catalytic, and interpretative. The procedural technique of facilitating self-expressive and other-expressive communications applies to new groups as well as to old groups. The therapist can fulfill the three functions mentioned above after his leader-defaulting during the initial meetings has firmly established in the patients' minds the fact that the therapist's leadership is neither didactic nor persuasive, but suggestive. While the concept of leading by default defines the negative aspects of authoritative, directive pushing, however, it does not really define the role that the responsible therapist plays in order to assist a group to develop a therapeutic democracy.

It should be useful to a group to have a member with experience and professional training in communication and interpersonal processes. One is reminded of Harry Stack Sullivan's (1951) opinion that patients are justified in their anticipation that a psychiatrist or a psychologist functions as an *expert* in interpersonal relations. By helping the group to develop its own culture of free communication, by helping the neurotic patient, who in a very real sense is a lame man in interpersonal functions, to overcome his difficulties, we interpret our role in the spirit of the expert as defined by Sullivan.

Initial group tension and resistance has three sources: First, there is a realistic disappointment in anticipated leader function; secondly, frustration of set-up attempts (transference) is a factor; and thirdly, groping for goal structure and paths for group locomotion is accompanied by anxiety. Resistance then has dynamic significance in the group. It is a symptom of low morale that is characteristic of groups unsure of their ground. If we add to the low morale factor the inner personal conflict that stems from the need to communicate and expose one's emotional difficulties, one can readily see why a group therapist should expect a fair degree of tension as being characteristic during these initial phases of group therapy life. The inexperienced group therapist attempts to manage the resistance and low morale factor by responding directly and didactically to the group's quest for authority.

A basic principle of management can be stated as follows: The group's low morale and disappointment in the early phases is the price it pays, the gate it has to pass, in order to develop the capacity to make use of the therapist as an expert, rather than as a fantasy figure or transference object only. Thus, there is in a way no management of the initial resistance. It is a natural phenomenon, a step toward a healthy group therapy culture.

Cues to the therapist concerning the proper time to function again in a more active leadership role must come from the group. The group will indicate, by a very simple behavioral device, that they have arrived at an attitude which assumes that the therapist will not help them in terms of direction, advice giving, and the like. This behavioral device is the postural adjustment of the heads of the members while they speak. In a leader-centered mood the speaking heads are turned to the therapist. When most of the members in the group have learned to speak in the direction of the member to whom their remarks are pertinent, the therapist can feel that it is quite safe to resume more active leadership to perform the three functions outlined above.

When a new group has weaned itself from the initial attitude of dependence, the therapist can give a brief description of various aids to communication. He may then give a brief description of the helpfulness of discussing dreams, and feelings about each

other in the group. At this point the therapist may also mention the psychodrama, projective drawings, "going around," or any other technique of interest to him; these activities will be described in Chapter 6. With the introduction by the therapist of available activity vehicles, the initiating phase of his work with the group is completed and the actual therapeutic work can begin.

## Chapter 5

### COMBINING INDIVIDUAL AND GROUP SESSIONS

---

#### The Group-Centered Interview

Beyond initial diagnosis, preparation, and introduction, many group therapists make themselves available to their patients for individual consultations. Group therapists, working in the pressure environments of hospitals and clinics, are happy to note that for many patients group therapy without individual sessions has proved remarkably successful (Powdermaker and Frank, 1953), but no one has been able to provide convincing proof of the theory that the therapy group, as we know it today, is a self-sufficient medium for intensive psychotherapy. No one denies that auxiliary individual work can increase the therapeutic effectiveness of group participation, yet this is not necessarily true. It is true only when the individual sessions are handled appropriately and coordinated to the group therapy experiences of the patient.

Powdermaker and Frank (1953), as well as other group therapy practitioners, have noted that regular individual sessions do, under certain conditions, drain off material from the group meetings. On the other hand, it is also observed that the majority of patients tend to avail themselves of individual interviews whenever practical in addition to their group participation. Present knowledge is too scanty to recognize fully the conditions that for a different patient or group would indicate the need or the lack of need for individual sessions. However, it is possible to say something about the conditions under which, when as in our regime individual sessions are used by most patients, drainage effects can be prevented.

In our private practice, new patients expect individual treatment and demand it. Our patients are referred to an individual



therapist, not to a group (institution or staff). Consequently, the private patient explicitly does not anticipate group treatment. Rather, he expects to receive individual attention. But once the patient accepts group treatment and is properly placed, the problem of therapeutic management is very similar to that of the institutional setting. In all settings one goal of therapeutics is to make the most efficient use of the therapist's time. Naturally, the more therapeutic services we can get out of the group medium the less we need to employ the expensive and time-consuming private type of therapeutic contact. Thus, the question, "Are regular individual consultations necessary?" is of crucial practical and theoretical significance.

At present we do not know enough about what the optimal psychotherapeutic process is fully to answer this question. A suggestive observation is the fact that neither Powdermaker and Frank (1953) nor this writer are able to distinguish, in terms of either speed or depth of therapeutic movement, between those patients who seek individual consultations less often, or not at all. In our setting we let the patients know that the therapist considers individual contact a helpful but not absolutely necessary adjunct to the group process. But patients are also told that, after they feel secure and learn to use the group, it is up to them to determine the amount and regularity of individual contact required. In response to this permissive regime the patients differ widely as to the amount of individual time requested. There is a trend for the more advanced patients to rely entirely on the group for their therapeutic work. Our follow-up questionnaires, which we routinely send every year to former group therapy patients, occasionally contain the item that, in retrospect, patients would have liked to spend more of their time and money on group meetings rather than on individual sessions.

The most crucial factor in the clarification of the question, "how much individual attention," concerns the way the individual session is handled by the therapist. It is well known to group therapists that concomitant individual treatment may "drain" the therapeutic effects of the group. The author's own exploration of the concomitant use of individual analysis (by analyst colleagues) seems to strengthen the impression that "parallel" treat-

ment is not conducive to progress as measured by the Leary technique. (In this technique one analyzes interactive protocols of group meetings, looking for the patient's change from ego-centered to other-oriented behavior.) Group members undergoing concomitant intensive individual therapy fail to keep pace with most other members' change from ego-centered to other-centered communications. In comparison to patients who either have no individual attention at all or whose individual therapy sessions are focused on their group experiences, the therapeutically managed patients whose individual sessions are nondirective, that is, without limiting the content to group experiences, are much slower to understand their here-and-now contact operations in the group. These patients seem to remain longer in a narcissistic, egocentric frame of reference.

On the basis of these observations our individual sessions are explicitly structured to the patient to have the function of going further and "deeper" into his relationships to the members of the group. The patient's tendency in the individual sessions is to use them as an opportunity to involve the therapist neurotically (transference) or to bathe in the fantasy experience of complete acceptance, or to flee into the past. In our technique these three tendencies are interpreted as resistance to looking at some repressed element in the patient's interpersonal experiences in the group.

"Group-centered" individual sessions are extremely helpful to the patient. They bring into focus new perceptions and insights gained in the group. By looking at the group participation from the relatively safe vista of the individual session, the patient gains that amount of distance which experiments in perception have proved to be a necessary condition for new problem solving. Furthermore, focusing his interest on the here-and-now group behavior strengthens the patient's feeling of cohesiveness with the group. Identification with the therapist's evaluation of the importance of the group as the major operating ground for therapy also reinforces the patient's involvement in the group.

By assuming a group-centered attitude during the individual sessions the therapist can prevent the drainage effect of parallel individual treatment. Unless individual sessions can be group-

centered, it is better for the patient to have little or no individual attention.

### Individual Sessions as a Safety Valve for Group-Generated Anxiety and Tension

Tensions generated in a preceding group session are worked through in group-centered individual interviews. The availability of the group therapist in private sessions at all times, in principle, keeps the group boundary permeable. That is, the group can be either foreground or background for the patient. During times of strong threat and pressure, the group can shift from a foreground focus to one of secondary importance. The therapeutic process can oscillate between a personal experience vis-à-vis the therapist and personal experiences vis-à-vis the other group members. The tie with the therapist is maintained not only as a safety valve but also as a technique for reducing the inhibition of free communication arising from anxiety instigated by the group.

In speaking about therapy groups as anxiety or tension instigators, one should not imply that the group produces these anxieties and tensions out of a clear sky. Actually, of course, neurotic and psychotic patients are full of inner tension and anxiety. When they are gathered together, one can expect some concentration of tension, but the tension or threat is actually within the individual and ready to be released, rather than provoked by the group situation (cf. Chapter 21). As a matter of fact, it is remarkable how often the predominant mood of therapy groups is characterized by friendliness, mutual aid, and support. Rarely does an advanced therapy group give the neurotic patient any real basis for his displaced hostilities. The patients get anxious and disturbed, so to speak, by their own shadows.

The group contributes toward anxiety in this way: the greater freedom of communication evokes motivations that usually are not felt in solitude, for example, sexual impulses, jealousy, anger at authority, and homosexual affection. In other words, during group therapy sessions patients become aware of threatening feelings and impulses, and this produces tension. While the process



of becoming aware of repressed impulses is an essential part of all intensive psychotherapy, the accompanying tensions with possible depressions and exacerbation of other symptoms must be clinically managed in a way that gives the patient an opportunity to reduce and purge the emotional tension.

The group-centered individual session is the most effective procedure for the release of group-generated tension. When, for practical, economic, or for transference reasons patients cannot make auxiliary use of individual consultations, it can be observed that the group participation of such patients is more defensive, less self-perceptive, more other-oriented, more general, and less personal.

In group therapy regimes which do not provide opportunities for regular individual consultations, group therapists may become consciously or unconsciously anxious to avoid the evocation of anxiety and tension during group sessions, thus participating in the ego-protective maneuvers of patients who do not use individual contact. While one can agree with those colleagues who see their task as group therapy leaders in terms of the role of "threat reducer" (cf. Hobbs, 1951), the technique of threat reduction must be of a kind that does not inhibit the expression, externalization, and self-perception of conflictful and threatening material. Inexperienced group therapists respond strongly to the fact that group meetings are always emotionally loaded with tension. They are consumed with finding releases for the always present group tensions.

Without a fuller understanding of group tensions and of how to turn their very existence into therapeutic experiences for the patient, a therapist is almost certain to "throw the baby out with the bath." To minimize threat-producing stimulation in the group may indicate a projection on the part of the therapist of his own as yet relatively blind fear of or distaste for groups and the emotional atmosphere they produce which is much more confusing and, in many respects, more uncomfortable than the relatively smooth and quietly flowing type of communication which the psychotherapist is accustomed to in his individual work. Actually, one of the great advantages of the group approach is the very fact that groups permit the expression of strong emotions



(cf. Chapter 20). The concomitant use of individual interviews permits the patient fully and uninhibitedly to exploit the group medium provided the therapist has a group-centered orientation.

### Reinforcement of Perceptual Learning

In our combined individual and group approach, the group sessions provide the manifest affect and action material, the actual interpersonal experiences, while the individual consultations provide an opportunity for analysis and integration. As in the type of active dream interpretation suggested by Gutheil (1951, p. 248), where the "first rule is that of simplification of the manifest dream contents," so in the individual consultation the first rule is that of simplification of the varied manifest interpersonal contact operations that the patient exhibits in the group sessions. The task of the therapist during the individual consultation is to reduce the varied patterns of specific behavior of the patient to a few sentences, similar to the reduction of the dream content of long dreams to their crucial outlines. Unlike dream interpretation work, however, the therapist need not rely only on his own perceptions but can use the preparatory work of analysis which has already taken place in the group itself. In the individual meeting he simply confronts the patient with a summary of group consensus vis-à-vis this behavior.

The essence of this technique is to lead each patient in the individual session to examine that part of his group participation in which he himself can detect rather obvious differentiations in his reactions to the various members. The therapist simply asks the patient to examine what things he keeps from whom in the group and whom he talks to about what. This usually leads to an uncovering of such underlying repressed emotions as fear of others, love for others, avoidance of others, and a wish to come closer to others. When a patient, in a more advanced, progressive stage of therapy, has given up the transference compulsion and when his ego is strong enough to use the suggestive influence of the therapist in a realistic, critical way, the therapist can give more of what he himself has sensed about the patient's conflicts and struggles.

One, among several factors, that makes the individual session more suitable to the process of discovery lies in the more leisurely and distant atmosphere of the individual session. Here a patient will often volunteer an insight into a particular disjunctive contact operation with which he has been confronted in the group for several weeks, but in each case refused to admit the "touché" under the pressure from the group. Of similar dynamics are the many instances reported by patients in which they formulate their discoveries in individual meetings with one other member from the group. It is as if in talking over with one other person one's behavior in the group *in retrospect*, the patient is able to step outside himself and to see the back of his own head.

In early phases of a patient's progress, suggestive and interpretive contributions by the therapist are usually ineffective. In our individual meetings the same rules hold for timing interpretations and confrontations that have been worked out in individual analysis. The basic idea is for the therapist to verbalize only that which the patient has already given indication of readiness to accept, and/or which he may have been already repeatedly told by other members of the group. Never does the therapist confront the patient with an idea out of a clear sky. In the smoothly progressing model case, the patient adopts, through transitory identification, the therapist's interest-focus on interpersonal operation. This naturally leads to a curiosity about his own behavior—his effect on others and their effects on him. Eventually, insight into repetitive, compulsive patterns of feelings with different people will occur in the group life.

### The Individual Session as a Stage for Neurotic Set-Up Operations (Intensive Transference)

For some time the author has been interested in the references many patients who have individual conferences make to those sessions when speaking to the group. They may start a comment directed to someone in the group by saying, "As I said in my private session to Dr. B. . . ." His technique now is to let the patient finish, and then at an appropriate time later come back to it. He might say, "You mentioned to the group that you have

already told me privately this feeling that you have about Y-F." We quote one patient's response to my comment.

PROTOCOL NO. 3: "DRAINAGE" IN PRIVATE SESSIONS

S-F: Yes, I did. I guess I was hesitant about bringing it up here in the group. I think I don't want to bring it up here, but I know it is important for me. At least you think it is important for me to get the reaction of the other members, so I brought this problem up here again.

Therapist: How do you feel about having mentioned it to me already?

[S-F is silent; then some group reactions.]

Y-F: She thinks it's less important to tell *us*.

V-M: Well, why should she tell it again? She mentioned it already, and I know how that is. You have relieved yourself of it, and then you want to forget it.

Th.: Is it the feeling of the group that you all prefer to tell me certain things privately, rather than share them with the group?

S-F: Yes, that's right. That's it. I wonder why?

[Hilarious group laughter]

Obviously, the majority of the group got some sort of gratification from just thinking about keeping certain things from the group. Here we have a concrete instance of what is meant by leakage or drainage of material from the group by individual sessions. But this so-called "drainage" can be understood in more psychological terms; it can be utilized interpretively and constructively. Any attempt to withhold from the group an item of experience that is shared with the therapist makes possible the cueing to the individual patient of what kind of feelings he likes to hide from the group. We can, in fact, hypothesize that the material told the therapist individually is material that the patient is afraid of telling the group without the therapist's sanction.

The use of individual sessions provides a stage for experiencing neurotic fantasies concerning loyalty, betrayal, favoritism, exclusive possession of, and secret alliances with the therapist against the group. The patient must be confronted with these

possibilities. Such interpretations are given to avoid the pitfalls of parallel individual and group treatment, which, indeed, would drain from and weaken both. The technique is not difficult, for one reassures the patient (more by action than by words) that one does not indiscriminately divulge to the group items told in private confidence. The group therapists in Powdermaker and Frank's experience had "many repercussions" of their tendency to call attention in the group to something a patient had said in individual therapy. Often such remarks were regarded by the patients as a breach of confidence. At other times such behavior on the part of the therapist aroused jealous antagonism between patients as to who was closer and of more interest to the therapist. In our own regime the therapist's attitude is firm in the principle that he, the therapist, believes that it would be therapeutic for the patient to learn how to share all his feelings with the group as soon as he can manage to do so.

A special form of resistance occurs in response to confrontations of the patient's usage of individual sessions to withhold material from the group in order to have a "special" relationship with the therapist. The resistance seems to stem from the fact that such confrontations make it more difficult, if not impossible, for the patient to act out his neurotic fantasies without insight. For example, an interpretation may spoil the acting out of a neurotic fantasy to have a secret alliance with the therapist outside and against the group. When using individual meetings, the therapist must have a feeling for this type of resistance, which is quite unconscious on the part of the patient. As soon as individual contact is made, any therapist can be assured that the patient will not wait long until he attempts to make neurotic use of the arrangement by which he leaves the group and visits the therapist privately.

This neurotic response to individual sessions against the background of group sessions is a symptom of the well-known narcissistic possessiveness of personality disorders. In this case it can manifest itself with a peculiar intensity because of the background of the group, which makes the exclusive possession and incorporation of the therapist, the group's leader, an even greater temptation for neurotic acting out than in individual therapy. The



danger that patients may be overstimulated into an intensive transference neurosis by the group situation requires that the particular resistance of the patient against sharing all communications occurring in the individual session with the group is thoroughly discussed and worked through in front of the group. The effect accompanying this neurotic possessiveness is comparable to and is sometimes even more intense than the transference neurosis in intensive individual treatment.

There seems to be much neurotic satisfaction in the fantasy of exclusive possession of the leader of a group. In order to protect the patient from turning this beautiful fantasy into a nightmare of feelings of rejection, failure, and group ridicule, the therapist firmly insists that the individual interviews are part and parcel of the group program, that in principle their content should be open to the group, and that the gatekeeper of such an opening to the group should be the patient.

The function of the individual interview also depends on the quality of the culture of the therapy group. When, as in the case of a poorly managed therapy group, the culture has not progressed beyond stereotyped advice giving, the permissive and accepting atmosphere of the individual session is, in contrast, so much more conducive to emotional release that no one could or should convince a patient that his interviews must be "group-centered." If the culture of the therapy group is "bad," then the individual session is the only path to therapeutic work. One of the tasks of the group therapist is to help groups to grow away from a repressive, judgmental, advising court atmosphere and toward a group life characterized by increased tolerance for the expression of tabooed material, individual differences, and the like. When the circumstances are such that the therapist and the group fail to achieve progress in the group culture development, the individual sessions will have to carry the therapeutic processes. In a later chapter we shall be concerned with an understanding of some of the factors which make for good and bad culture developments in the therapy group.

An interesting form of private consultation takes place among the patients themselves. A number of patients, although by no means the majority, visit one another individually, in addition

to the total group meetings. These meetings do not, as a rule, drain from the group process, for, quite naturally, these private interviews between patients are "group-centered." Those who feel most insecure in their roles in the group try to select a suitable "private therapist" among the other patients who is willing to spend time and show personal understanding. It is not unusual that patients will, so to speak, preview the formulation and expression of feelings instigated by other group members in these individual meetings between two patients before venturing to communicate them freely in the group. The need for these individual, extragroup meetings usually is characteristic only for a certain phase in the therapeutic process. Group attendance and visits to the therapist show a considerably more stable pattern in contrast to the individual consultations which some patients render each other. The quality of the interpersonal relationship within these patient-patient interviews becomes as much part of the content of group discussion as does the quality of any given patient's relationship to the professional therapist during their private consultations.

### Use of Different Therapist for Individual Sessions

Unfavorable experiences, particularly of drainage effects, have taught us to shift from an unlimited, nondirective approach in the individual session to an approach involving "group-centered" consultations. Having come to this conclusion, we have found Slavson's (1950a) observation that it is unsatisfactory to have a different therapist for the individual sessions perhaps a little too final, but nevertheless wise, unless the individual therapist is also keenly interested in and keeps up with group events. This he can do by frequent visits to the group meetings and by conferences with the group therapist, who can reveal and report to him the interpersonal experiences had by his patient in the group. Otherwise, we get the evils of "parallel treatment" already mentioned, in which the individual therapist goes along as if the therapy group is just another "social experience" in the life of the patient. The result, of course, is that the patient identifies with this attitude and the therapeutic effectiveness of the group

medium is nullified. The negative effects of "parallel treatment" are recognized by most group therapists, who follow Slavson's recommendation that the individual and the group therapist should be the same.

Our studies so far have indicated that the situation of two therapists provides a peculiarly intensive type of activation and externalization of pathological motivations. The contact operations in the procedure with two therapists may involve the following presently recognizable patterns:

1. Rivalry and/or mutuality between the therapists. All the possibilities for unconscious problems involved in any interpersonal contact operation could be present, such as problems of identification, differentiation, confluence, castration anxiety, homosexual or heterosexual pairing, allying against the patient, and rivaling for possessing him. As a rule, in the cases of analyzed therapists, such unconscious motivations are sublimated into a closely cooperative friendship and work pairing devoted to the rehabilitation of the patient and to research into the dynamics of the clinical trio. Nevertheless, the patient often will projectively react to the unconscious dynamic possibilities that are always present in any close interdependent contact operation.

2. The utilization by the patient of the social field provided by the therapists' interpersonal contact operations goes in many directions, including the following: (a) reinforcing and keeping alive the unconscious conflicts between the two therapists, (b) elevating the self into an illusionary role of judge, (c) loyalty conflict *à la Oedipus* ("I cannot love you and him simultaneously. One of you must be wrong."), (d) reliving previously repressed constructive and/or destructive reactions to the observation of conflicts between brothers, friends, parents, etc., and (e) externalization of jealousy over being left out of a close friendship pairing (between the two therapists). The latter element brings to the fore otherwise repressed feelings of isolation, rejection, exclusion and displacement of love and hostility felt for one therapist but expressed to the other.

3. Also involved are the group's reactions, in which we have so far isolated the following: (a) participation in and a reinforcement of comparative attitudes, (b) jealousy on the part of



the group members with respect to their various respective individual therapists. (This may express itself, for example, in the comparison of publications in quality and volume, the comparison of hospital staff status, sex appeal, extensiveness of practice, community interest, or what not.) (c) Since some individual therapists tend to see their patients more often than others, the group's reaction to this fact gives expression to their feelings about excessive dependency, expense, depth of the therapist's interest, and the like.

Our present studies consider the three aspects involved in the method of using a different therapist for the individual sessions and for the group sessions, namely, a) the contact operations between the two therapists, b) the reaction of the patient to this relationship, and c) the reaction of the group. We shall eventually be able to evolve clinical principles to guide a full therapeutic utilization of the obvious potentialities theoretically present in the use of two or more therapists. Dreikus' (1950) studies promise to clarify this rather complex situation.

The present recommendation, meanwhile, is to have the individual sessions conducted either by the group therapist or by a colleague who keeps himself familiarized with the group members and their interpersonal activities. The focus of the individual session should be the group experience. This recommendation would be impractical if it necessitated that the conductor of the individual session also go to all group meetings. But it is not impractical for the individual therapist to structure his individual consultation so that the patient knows that he is supposed to work through his interpersonal problems with the other group members including the group therapist. In this way many colleagues, who with their own patients have a traditional frame of reference, can help the patients of the group therapist without weakening the opportunity fully to exploit the newly discovered therapeutic potentialities inherent in group therapy experiences.

### Using Two Clinicians in the Same Therapy Group

In many psychological training and research settings where group therapy is practiced and taught, two clinicians instead of



one work with the group. One is the conductor and the other is usually designated as observer, recorder or co-conductor. The major rationale for this procedure, at the present time, is the need for training opportunities and for research. Actually, the complications in the therapeutic management are multiplied by two. The relationship between the therapist and any group observer tends to complicate an already complex situation further. Possibilities of complications in the doctor-observer relationship may hinder, in the experience of Powdermaker and Frank (1953), both research and therapy.

Considerations of economy also speak against the use of two clinicians for one group. Until we know more about unconscious interpersonal dynamics in groups, the use of a second clinician should be restricted to clinic and university training settings; there the use of observers is inevitable. Our own experience with such arrangements has been interesting. Patients feel flattered that the group is important enough to have a special observer record its processes and summarize them. I always had the feeling that the presence of more than one professional person overloads the authority dimension in the group structure. It widens the existing split between two subgroups: the "normal authorities," and the abnormal, sick patients who very easily acquire a "guinea pig complex."

Since training and research are necessary functions, it should be pointed out that my relatively negative experience with observers and recorders is not shared by all colleagues. Joël and Shapiro (1950), for example, see considerable advantage in having "two therapists": a therapist and a co-therapist or recorder. These writers also mention that "two therapists, particularly if they are of opposite sex, more immediately revive the family situation." Reference to the reviving of family situations in the above quotation is the most popular stereotyped shop talk about the therapy group. The hypothesis that an adult therapy group of eight peers and two clinicians in any way, shape or form is a reincarnation of a situation of two parents and an average of two to three children fits well into the past time perspective of psychoanalysis, but does not provide a model that clarifies the dynamics of therapy groups as they really are (cf.

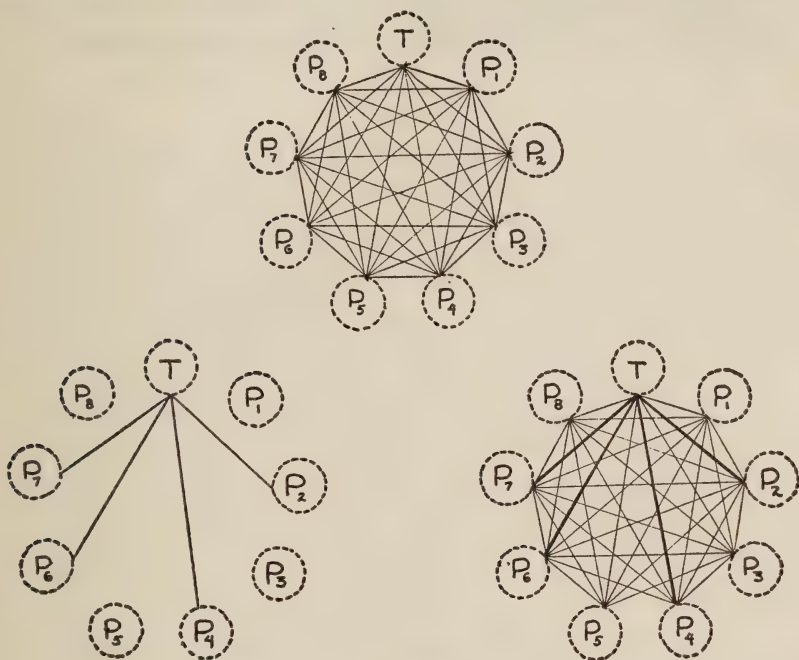
Chapter 19). Consequently, using the family analogy as a scientific argument for the use of a second observer is not acceptable. It is more likely that in addition to the training function, the second clinician serves some other needs of his and of his colleague, such as sharing the group hostility.

### Individual Sessions as a Factor in Intensifying the Central Role of the Group Leader

All clinicians are agreed that a successful group therapy practice must be group- and patient-centered, rather than functioning by authority of the leader. In examining the program by which patient-members of a therapy group come to see the therapist individually from the point of view of group-centered versus leader-centered considerations, we must be concerned with the possibility that such a program strengthens, rather than dilutes, the authority and leader position of the therapist in the group. Actually, one need not invoke any mysterious hypothesis concerning unconscious emotions about leaders. One need only to be reminded of the work of Alexander Baveles (1948) and his co-researchers on communication dynamics at the Massachusetts Institute of Technology. There they found that leadership authority is assigned in a small group of individuals to those occupying the most central position in a pattern of communication linkages.

We can represent two comparative group therapy situations in a figure. In Figure I the top drawing shows the communication network when the therapist confines his contacts with the patients to the group meetings and has no individual contact. The drawing on the left of Figure I represents the fact that four out of eight patients see the group therapist individually on a regular schedule. The right drawing in Figure I represents the strength of the therapist's central position in the communication network of the group brought about by the concomitant use of regular individual sessions. The implications from the point of view of a group-centered as against a leader-centered therapy regime may not *all* be unfavorable, but the group therapist must be aware of what effect his seeing some group members indi-

vidually has on his leadership position in the group. In our practice, we encourage group sessions without the therapist (post-sessions) in order to offset the excessive centrality or power position of the therapist as much as possible and to facilitate communication between members.



Changes in therapist's leader position resulting from seeing patients individually

The factor of the therapist's centrality, from a point of view of therapeutic efficiency, suggests a policy of restricting individual contacts to a minimum. Experience has shown that individual consultations increase dependency on the therapist and that they may encourage neurotic contact operations involving the therapist. Individual contact may have the effect of over-emphasizing the centrality of the therapist's position in the group. This would affect the development of a patient-centered group culture adversely.

In deciding how much individual contact the group therapist would encourage with any particular patient the various pros and cons discussed in this chapter may be considered. In general, individual therapy contacts are most helpful to those patients who can quickly and smoothly give up the temptation to make neurotic transference or resistive use of such contacts. Concomitant individual consultations do, for many patients, increase the psychotherapeutic effects of group participation.



## Chapter 6

### MAJOR VEHICLES AND THEMES OF GROUP COMMUNICATION

---

The word "theme" has long been popular in psychology and psychiatry. The theme concept has been found helpful by several group psychotherapists who, in the process of research, try to break down the complexity and extensity of group proceedings into observationally "natural," organismic units. Powdermaker and Frank (1953) noted that in spite of great individual differences among patients in terms of complaints, background, and interest patterns, certain themes persisted over a series of meetings during which a majority of the patients developed successively more intensive interest in them. Some of the themes holding the interest of the majority of group members were labeled by Powdermaker and Frank as follows: ambivalent feelings about loving women; hostility, distrust, and fear of people; feelings of inferiority and desire to be average; and blaming others versus accepting responsibility.

Defining "theme" in this sense, Hobbs (1951) writes:

. . . A theme is a topic and point of focus in discussion, with a clear beginning and a clear stopping point. There may be one or a number of themes in a single session, usually there are several. For each theme, there is a major participant who is the center of focus, and there are minor participants whose number and intensity of involvement vary from theme to theme. In a series of sessions, some themes are short-lived; they are brought up, examined briefly, and abandoned. Other themes spread their way throughout all the sessions. . . . The technique [of theme analysis] has been used in several investigations of the process of group therapy. . . .<sup>1</sup>

<sup>1</sup> Quoted from C. Rogers, *Client-centered therapy*, by permission of Houghton Mifflin Co.

For our present purpose "theme" is defined as a regularly recurring concentration of group interest on one common project which is simultaneously undertaken by a majority of the group's membership. In addition, themes are defined in terms of temporal oscillation, in terms of content, and in terms of instigation. With respect to the last, we distinguish between spontaneous and programmatic themes. Every theme has a characteristic tension development from initiation to termination which we call a "wave unit," because during the temporal progression there are changes in intensity of interaction in the group.

It is typical for groups to communicate, say about theme X, in a "wave-unit" fashion. The analogy to the ocean's wave activity comes to mind. Starting with a lull in communication, there is a gradual involvement of the whole group with a peak of interchange around a topic. Powdermaker and Frank (1953) have independently observed this phenomenon and have called it *rallying around a topic*. Gradually interest, percentage of participation, and the intensity of emotional involvement wane. Fewer members make comments, until finally there is only one member left who remains interested, until he too senses the group's satiation and no longer communicates on a particular theme. The wave has come to an end, has reached the point of "theme satiation." The wave-unit nature of group communication permits the therapist to distinguish empirically between themes, count the incidence of each, and watch for change.

The rhythmic character of group communication has some implications for therapeutic leadership. For example, even the least directly participating therapist would help the group to gain closure at the end of a wave. The therapist, on observing that the group has come to a satiation point, prevents tensions resulting from satiation and helps the group to move on. Also, for other types of contributions on the part of the therapist, such as making an interpretation, it would be helpful for him to know that any contribution from him to the group concerning an interpretive, rather than a participative, nature would, in fact, have no chance of penetrating, if it is given at or near the peak of the interaction wave.

## Major Themes Discussed by Patients in Group Therapy

What are the major themes that group therapy participants like to discuss? Table II gives a sample of the relative frequency distribution of the various themes which our sample groups I and II participated in during one hundred consecutive sessions. This series was arbitrarily chosen on the basis of availability of recordings, observers, and the like. Table II also suggests relationships between theme, group-developmental phase, and communication level, which are discussed in Chapter 16. A brief description of the sixteen themes listed in Table II follows:

TABLE II

MAJOR COMMUNICATION THEMES DURING ONE HUNDRED  
OFFICE MEETINGS OF THE TWO SAMPLE GROUPS I AND II

	Number of Sessions in Which Theme Occurred		Develop- mental Phases of Group Life *	Communi- cation Levels *
	Group I	Group II		
1. Symptoms and confessions ..	26	18	I, II	1
2. Psychology, therapy goals and values .....	69	41	I, II	2
3. Emergency situations .....	63	28	II, III, IV	1
4. Historical perspective .....	100	100	III, V	2, 4, 5
5. Advice giving and taking ...	100	100	III, IV	2, 4, 5, 6
6. Dream reporting and analysis	89	92	II, V, VII	3, 4
7. Role playing .....	84	92	II, V, VII	3
8. Projective drawings .....	18	10	II, V, VII	3
9. Awareness of group process, etc. ....	100	100	VI	3, 4
10. Psychometric assessment ...	4	6	VI, VII	3, 4, 5, 6
11. Boundary analysis .....	12	18	VI	3, 4, 5, 6
12. Analysis of subgrouping ....	31	47	VI	3, 4, 5, 6
13. Analysis of social activities ..	74	63	IV, V, VII	2, 3, 4
14. Going around .....	25	6	VII	4, 5
15. Analysis of effect others have on self .....	100	100	VII	5
16. Analysis of effect of self on others .....	100	100	VII	6, 7

\* For the definition of "developmental phases" and "communication levels" see Chapter 16.

*Theme 1: Symptoms and confessions.* Patients discuss what troubles them, what personal problems brought them to psychotherapy, and the benefits they hope to derive from it. They confess what they may be ashamed of in their personal life. New patients seem to find it necessary to give confessional material first, perhaps as an "initiation" to a psychotherapy group.

*Theme 2: Psychology, therapy goals, and values.* Patients discuss techniques, theories of psychotherapy, implications of mental hygiene to community life, ethics, psychosomatic medicine, and the like. Patients seem to have a need for coming to terms intellectually with the reality in which they are now participating in a psychotherapeutic process.

*Theme 3: Emergency situations.* Patients exchange their acute troubles, which in this theme they blame on the inadequacies of the social or material environment. In this way they sometimes reinforce, sometimes effectively counter, what Bergler (1946) has called the neurotic patient's "basic fallacy": the defensive displacement of the cause of neurotic frustration from the self to the environment.

*Theme 4: Historical perspective.* Patients discuss their past life and exchange emotionally important episodes of past interpersonal, especially familial, relationships.

*Theme 5: Advice giving and taking.* Patients advise and direct each other what to do or not to do. They play the Dale Carnegie role of guiding others toward more efficient living. Then they examine their motives for offering the specific advice to a specific member of the group; invariably the group's guidance services are found useless. Patients react strongly to being "pushed" and diverted, even though they ask for it.

*Theme 6: Dream reporting and analysis.* Patients tell dreams and everyone gives associations. The therapist summarizes the associations and may give his own. Dream reporting triggers associations which go by chain reactions, each member giving associations to the associations that other members had to the dream. The manifest content of the dreams often includes group members.

*Theme 7: Role playing.* Patients engage in informal non-prepared, spontaneous "psychodrama." They enact scenes in



which a given patient acts out tension experiences. Some groups make use of fantasy supports, such as the MAPS miniature stage in the play drama (Bach, 1950a).

*Theme 8: Projective drawings.* Each patient has a tablet of drawing paper and a box of crayons is available. At some meetings groups may decide to draw as a warm-up technique for discussion. Each may draw his own picture, then hold it up for associations, or the tablets may be passed around, every member adding to the picture. All art products are discussed when completed.

*Theme 9: Awareness of group process, leader role, membership, etc.* Patients discuss their awareness of group atmosphere, roles, and needs of the group to manage its own life. The majority decides what to do and whom to invite into the group. Authority and leadership are subject to the group's sanction in free participant groups.

*Theme 10: Psychometric assessment.* Patients fill out group-designed questionnaires on who would do what with whom in the group. Members tabulate, analyze, and discuss results. Older group members compare their assessment reactions to previous assessments.

*Theme 11: Boundary analysis.* Discussions reflect in-group consciousness vis-à-vis the outer macrocommunity. Concern with in-group maintenance and the defense of the group's psychological boundary finds expression in discussions of absenteeism, turnover, visitors, newcomers, differentiation from other psychotherapy groups, from other leader-therapists, and the like. The theme includes the group's concern with discretion in disclosing to "outsiders" what is revealed in the group.

*Theme 12: Analysis of subgrouping.* Every therapy group has a shifting structure of subgroups, expressed in changing heterosexual pairings, coalitions, alliances, contestants, isolates, leaders, and other roles. Group members take a keen, spontaneous interest in changes in the subgroup structure, which they like to control or influence in certain directions. They discuss these matters frequently, especially in our regime where extraclinical, social meetings are regularly held.

*Theme 13: Analysis of social activities.* The patients discuss behavior incidences experienced in the post-sessions or parties to which the majority of the group has strong emotional reactions. Personal preferences and rejections are acted out during the social or play phase of life in the therapy group. These acting-out patterns are analytically discussed and worked through during the clinical office meetings.

*Theme 14: Going around.* This is a warm-up technique introduced by the therapist to get to a more emotional, less intellectual-defensive level of communication. Each member describes his feelings as to how every other member in the group affects or strikes him emotionally. In new groups this is usually done from neighbor to neighbor, "going around" the group circle.

*Theme 15: Analysis of effect others have on self.* The repeated use of the going-around warm-up soon leads to an independence of it. In advanced groups all patients discuss at any time how anyone in the group affects them.

*Theme 16: Analysis of effect of self on others.* In every meeting advanced members are curious about how they affect other members. They inquire of each other about the quality of emotional impression, for example, anxiety evocation, or affection, which they may have on each other. The conventional agreement to express feelings truthfully insures fairly revealing and frank answers. The ensuing discussions often include attempts to relate the group's findings in respect to experiences with other people, past or present. Such attempts at integration of experience and insight are responded to with interest by the therapist and reinforced by other group members. Advanced patients often seek individual therapy sessions to find an occasion suitable for the facilitation of this integrative process.

### Spontaneous Versus Programmatic Themes

From the point of the therapist's role, the sixteen themes summarized above can be divided into two categories: spontaneous and programmatic. The first five themes discussed above and summarized in Table II represent what may be termed

a spontaneous type of discussion. In contrast, the other group activities are called "programmatic" because they represent group behaviors which are initiated by the therapist and official conductor of the group. Since, from the point of view of clinical management of psychotherapy groups, the therapist-initiated or "programmatic" activities are of more immediate interest than the spontaneous themes, they will be discussed in more detail in the following chapters. A report by the author of the details and implications of the first three spontaneous, group-originated themes can be found elsewhere (Bach, 1953*b*). Space considerations limit us here to a discussion of only two of the five spontaneous themes: historical perspective, and advice giving and taking. This discussion will be presented in Chapters 7 and 8.

### Clinical Implications of Therapist-Instigated Programs

Except for the first five spontaneous themes, all other group proceedings owe their initiation to the structuring and planning hand of the professional group therapist. Although the major form of interaction in our sample groups I and II is free-for-all discussion, these discussions are frequently stimulated by therapist-instigated programmatic activities, such as projective drawing and dream reporting.

To have or not to have "programs" (as against "free-floating" discussions) is a controversial point of technique in group therapy. The controversy revolves around the question, "Should therapy groups have programmed activities at all?" One side, emphasizing the group-centered aspects of treatment, says, "Programs are always thought up by the therapist; they are group-alien factors; they spoil spontaneity." The other side, while agreed on the virtue of spontaneity, believes that such spontaneity can be best developed through proper stimulation. The antiprogrammatic side is most radically represented by the "leadership defaulting" expounded by Foulkes (1951*a*). The so-called "group-centered" therapy practiced in the United States by Hobbs (1951) also excludes therapist-instigated activities. The programmatic approach which is taken in this book was first

developed by Moreno (1946), who attempts to develop the spontaneity of his patients on the psychodrama stage.

The antiprogrammatic approach specified, according to Foulkes (1951*a*), that the patients meeting in groups of seven to eight

. . . are not given any aim or object . . . no set topics or program for discussion. Instructions are kept to the bare minimum. The discussion is completely loose and undisciplined, a free association of ideas which can best be described as a "free-floating discussion." . . . The therapist, the natural leader of this group, does not assume active leadership. Moreover, he is not primarily concerned with the formation of its members into a good and efficient group.

Foulkes calls this, his own approach to group therapy, "peculiar," "oblique," and "astonishing." The therapeutic efficiency of the antiprogrammatic and leader-passive approach is openly considered to be of secondary significance to the supposedly ideal opportunities for making research observations on leadership functions and group formation processes. In our view, the role of a participating and observing catalyst who is essentially passive is only one of many therapeutically effective roles. It is a role evolved from clinical experience in individual settings and is undoubtedly effective in the individual therapy setting.

Many of the objections to a more active role of the group therapist, which would be involved in his introducing "programs" and planned activities other than spontaneous discussions, are, in the author's opinion, remnants of the very common hanging on to methods utilized in the individual approach to psychotherapy. Teaching group therapists not to take a more active, natural part and warning them against helping patients to develop interaction vehicles other than ordinary verbal communications are symptoms of professional conservatism. The current conservative need for adherence to therapist roles suitable for individual work but unsuitable for the group approach will disappear as greater attention is paid to exploring creatively various possibilities for new roles suitable to the therapeutic medium.

The main value of programmed and organized group activity, with all its drawbacks, is to further the cohesiveness of group



life in its initial phases and to provide structure, that is, reduce the initial anxieties over what to do on the part of new members and, parenthetically, new therapists. Both find themselves in unstructured and strange territory. Organized activity also facilitates the participation of the perennially silent members, who admittedly do not get their share of interaction in the psychoanalytic type of group therapy program wherein only "free discussion" takes place.

The so-called "free discussion" method introduces many complications into therapy group proceedings. The narcissistically dominant and the paranoid manic tendencies blossom and give the life of the therapy group a high degree of tension resulting in "insane" group atmospheres, which have been so eloquently described by Bion (1948-51). It may not be amiss to suggest that some of the group emotional irrationalities, described by Bion as "basic," unconscious assumptions underlying group life, are only a reflection of the incongruous or even socially perverse situation in which an official and sanctioned leader defaults in his job. The primitive group-emotional trends of fleeing and fighting, sexual pairing and depending, may be a characteristic of any group, neurotic or normal, which lives under a *laissez faire* regime. In clinical *laissez faire* groups, a work orientation toward self-other analytic perceptions (themes 15 and 16) can emerge only by chance, for such an orientation depends in great part on the therapist's role and attitude.

In actual practice, however, no therapist really defaults. He is the official, the most educated, the doctor-host. The group senses that he attends with more satisfaction when the group engages in therapeutically useful processes. He makes apparent his leadership role in the timing and content of interpretations and reflections. Thus, the "leader method by default" is a semantic model, never approximated in reality. This controversy then is really about an improbable model. Even if some specifically trained group therapist, for research purposes, role-plays a high degree of manifest defaulting leader-behavior, the group would on an *unconscious* level set him up as a leader and experience leader-follower emotions anyway.

## Programs Strengthen the Group's Autonomy

The most common criticism leveled against expanding the medium of interpersonal exchange from "free-floating discussion" to therapist-initiated activities introduced by the group therapist is that such an introduction would necessarily reinforce the authoritative role of the group therapist. It is said to produce the undesirable atmosphere of leader-domination rather than group-centeredness. There is no intention here to deny that, even when using genuine group decisions concerning whether or not to use a group program, the therapist is the main force behind the *initial* introduction. This temporarily has the undesirable effect of strengthening the central or power position of the therapist-leader. Insofar as one likes to produce a culture in the therapy group characterized by absence of fear of hierarchical figures, it would, of course, be undesirable to maintain such an effect beyond the unavoidable initial phase. However, there are ways in which the therapist can function toward the patient in the group in a service role, analogous to that which a librarian fulfills in locating and directing the reader to the appropriate section of the stacks in which he knows the reader will find books of interest to him. In providing programs we presume that we give expression to a spontaneous group demand for structuring pathways toward freedom of self-expression. If this is done correctly, group cohesiveness is furthered and leader-dependency actually weakened. After initiation by the leader, a group routine can become established independent of leader-direction.

The field of psychological forces represented by the conscious and nonconscious emotional exchanges among members of a therapy group creates many roles that must be filled for the attainment of the fullest and smoothest functioning of the group life. The passive reflector is only one group-created and group-needed role. It is one not necessarily best filled by the expert, official conductor of the group; in fact, it can be very well filled by almost anyone else in the group. In a permissive and cohesive group culture, everyone should help everyone else by summariz-

ing and reflecting upon manifest as well as unconscious content. The selected recounting of participant observations is a role that everyone can learn quickly and is an easy and secure way of relating oneself to a group. In our approach, everyone, not only the official therapist, participates in fulfilling this role.

Among the group-created roles, however, there are some which require technical skill and a knowledge of the psychological dynamics of group life. This is especially true in a therapy group which, because of its high degree of democracy, has little or no precedence in the life experience of its members. Because of its code of "freedom of expression," the structure of the therapy group is unknown territory to the patient-members, while it is presumed to be known, familiar and nonanxiety-evoking territory for the official leader. The group often needs someone to structure, to help map this new territory and to point out ways of moving in it. Initially only the therapist can fulfill this role which, among other aspects, takes the form of structuring and providing vehicles for facilitating locomotion toward the group goal, giving as free expression as possible to suppressed and repressed feelings and action tendencies.

### Five Specific Clinical Advantages of Organized Activities

1. *Contrasting individual performance against backgrounds of various group activities.* One of the goals of psychotherapy is that every patient is helped to recognize the quality of his interpersonal approach-avoidance patterns. The use of a variety of group programs facilitates locomotion toward this clinical goal. Different programs make it possible to contrast the type of group participation the same patient may engage in under different conditions. For example, the patient who is reserved and cooperative under the discussion method becomes hostile and aggressive under conditions imposed by a role-playing program. A variety of group activities stimulates discussions concerning the comparison of differences in behavioral roles in the different types of group activities. A very meek, withdrawn, inhibited patient was considerably relieved, after initial amazement, to

discover that he was able to express a large amount of hostility in the role-playing activity of the play drama, while having a very low percentage of hostility responses in the other more realistic activities. Such differential experience permits the patient to understand different aspects of his personality and social roles. It makes available to the patient cues to focal points of behavior change. The patient's attempt to learn new social habits or unlearn old ones is facilitated by the process of pointing up his personal approach as the foreground against a background of a variety of group activities.

2. *Programs tend to equalize participation of the weak minority.* Another advantage of an organized group activity is its dispersing effect. A program is a fresh experience common to all. The initial stimulation may have come from the therapist, but the group decides to enter or not to enter into it. A program helps balance the source of stimulation, which is otherwise dominated by the few members who are the most expressive-communicative. In organized activity the shy and relatively non-expressive, nonexhibitionistic, silently observing member is given a better chance to start on and maintain an equal footing. Those whose lives, by our cultural standards, are relatively "dull" and routine have a chance to relate themselves to those with more "exciting" outside lives. It makes for group-centeredness by stimulating interaction concerning what is happening, what is done here and now in the group.

3. *The therapist's anxiety-reducing role is essentially unaltered by programs.* Whatever the content of the activity, the leader always helps patients to focus attention on the emotional quality of the communication. Programs reduce the emotional anxiety over free expressiveness, but they do not, by themselves, bring out any emotional content of peculiar value. But since the patients can participate with less anxiety, the emotionally unconscious, latent quality of interpersonal communication is more easily recognizable by therapist and patient than when the group's activity is restricted to the inhibiting discussion medium.

4. *Activity programs help to externalize defenses.* Another argument for group therapy programs, and against restricting the group life to the discussion method, comes from the fact that



group activity programs encourage acting out. Acting out provides another way of externalizing the patient's defense. In intensive group therapy, acting out is like projective responses in dreams—the impedimenta, the implements of perceptual and insight training.

5. *Programmatic rituals help to differentiate the culture of the microcommunity of the therapy group from the everyday culture.* The introduction of a variety of programmatic activities has the effect of creating a special clinical work culture, which group therapy programs restricted to discussion are slow to develop. The goal of organized group activities is the creation of a particular clinical culture to facilitate a differentiation of the larger community group life from the microcommunity of the therapy group. In programs the attempt is made to remove the person from the ordinarily repressive, suppressive, and action-denying forces of the broader culture. In the larger community of everyday life, talking and discussing is governed by sometimes explicit, but mostly implicit conventions of logic, fluency, proper grammar, good vocabulary, and the like. Furthermore, such conventions as good manners and politeness are all in the direction of keeping interpersonal conflict at a minimum.

A therapy program restricted to verbal discussion inadvertently brings into the group therapy room an uninvited guest of cultural conventional repressions (cf. the many proverbs and sayings which warn people against the free use of the tongue). Verbal discussion methods make the task of interacting on an "emotionally free level" difficult and anxiety-evoking. Discussion groups frequently develop a glib lingo, reciting "insights" with great facility. But the signs of repression which conventional verbal communications bring with them are unmistakable to the insightful observer. Resistances are unnecessarily intensified through presenting the patient with a difficult paradox: The patient is asked to express himself freely, and at the same time, he is provided with the same medium, namely, conversation, in which, throughout his life, he has been taught to keep his thoughts to himself and to express only that which is in accordance with a conventional standard of politeness, aggressiveness, charm, and propriety.

The group therapist who feels that by the introduction of programs one strengthens the central or power position of the authority figure overestimates the importance of the therapist as a central person. Actually his importance is reduced when the group culture is established, for it sets up leader role sanctions through which anyone who wishes to lead is critically analyzed concerning his effect on the group (cf. Chapter 19). It is true that in the initial phases of a culture in the therapy group, the therapist is the keeper of the gate through which therapeutically valuable programmatic activities are introduced. But, once ritualized programs are a part of the group life, they in no way necessarily involve the therapist as the authority figure.

## Chapter 7

### SPONTANEOUS DISCUSSIONS: FACTS RELATING TO PERSONAL HISTORY

---

The discussion of the adult patient's own past relationship to his parents, siblings, and other significant figures in his life is a very popular theme for therapy group discussions. The number of personal history references in discussion groups has been found a mark of differentiation between highly cohesive groups concerned with important issues and noncohesive groups. Schacter (1951) suggested that "reference to personal history may be considered evidence of real involvement in the discussion." Since in psychotherapy, groups have a high degree of cohesion, it is not surprising to find that the theme of life histories occurs at every meeting of the two sample groups.

#### The Issue of Historical Interpretation

Many psychotherapists look upon the therapy group primarily in terms of a setting where experiences in family group life are relived. There is, indeed, a spontaneous historical direction in the free-floating discussion. In psychoanalytically oriented group therapy approaches, this trend is explicitly or implicitly reinforced by the therapist's interest in historical material. Many psychoanalytic group therapists consider it their primary role to interpret the patients' present attitudes in the group as compulsive repetitions or "relivings" of earlier life phases. Even when, as in our present regime, the therapist rarely offers historically slanted interpretations, the patients themselves are very generous with them. They are always interested in finding some reasonable historical motive or "cause" for their present neurotic illnesses. Figures of importance in the past life serve well as objects of displacement. By considering them as the original

"causes" of a present difficulty, an ego-protective rationalization for the presently manifest failure to adjust to life is sought.

For the purposes of psychotherapeutic techniques, the issue of historical interpretation raised in the preceding paragraph is largely irrelevant. Clinical experience demonstrates that some historical orientation affords many patients, especially hysterics, significant relief from tension. When a patient believes that he has, through some insight into an uncovered historical episode, gained an "explanation" of his present puzzling personality disorder, his tolerance for threats to the ego accruing from insight into the present conflict increases. Clinicians are interested in reducing the patient's anxiety and, therefore, would never disturb such a faith.

Clinical observation also shows, however, that many patients (other than hysterics and psychotics) overcome very severe emotional handicaps without participating in any significant way in historically oriented communications. Like all questions of defenses, the problem involves the degree of security or strength of the ego. Patients with less vulnerable ego structures need to involve themselves less in the historical rumination of "unfinished business" in order to face their present difficulties. As has been pointed out by Wolf (1949-50), in a group the ego of the individual is strengthened by identification with the group; the patient therefore may not need so much of this type of security as he may need in individual treatment.

### **Memory of Past as Defense Against Present Threats**

It is typical for groups to discuss historical material primarily through the springboard of here-and-now family and group tensions. This is understandable when we realize that most psychoneurotic patients suffer from a "weaning-overdue" condition. Rather than "reliving" the past, they are actually still struggling with the same problems of gaining more freedom of locomotion that they had when, as young children, they struggled with their parents. There is no need to think of all present



neurotic difficulties as being occasioned by relivings or reactivations. Neurotic problems often are more in the nature of perpetuations or fixations of interpersonal relationships that would have changed or dissolved in a less pathological course of personality development. This position in no way underestimates the importance, from a practical clinical standpoint of the need of the patient, when confronted with a difficult present situation, to invoke the memory of past situations as a defensive method for overcoming present threats to the ego.

In the following protocol it can be noted how, in the individual interviews following the group discussion, the patients are obviously relieved to find that they can superimpose their present frustrations with their "absurd" neurotic behavior onto their past experiences and onto "bad" parental influences. This protocol on the topic of "mothers" is taken from one of the sessions of Sample Group I. There were eight members present on the evening the recording was made. The excerpt occurred early in the session following a lull. One patient, E-F, had a few minutes earlier mentioned the fact that every time she brought up the topic of mothers the group had dropped it. Now E-F is again ready to press the point.

#### PROTOCOL NO. 4: "MOTHER"

E-F: Let's talk about mothers at twenty-five after eight P.M.

D-F: Why don't we talk about mothers now?

Group: Yeah.

B-M: You're on!

E-F: I tried it at a post-session once, and we discussed it very briefly, and then we promptly went on to politics. I think the subject of mother is as threatening to everybody else here as it is to me.

G-M: Why don't you start it then?

Therapist: Why not discuss your own mother feelings?

E-F: Well, I have loads of hostility feelings about my mother, and I have loads of guilt feelings over this hostility.

D-F: So you're not alone, dear.

E-F: My mother is leaving my house next week by my special request. I feel the whole visit has been a flop. I feel I could have

enjoyed her if I could have handled it right. [Pause] My way. And I didn't. I wasn't able to.

E-F: What do you mean she's leaving, leaving your home or . . .

E-F: She's going back East.

G-M: How did you request her to go?

E-F: I tried it in letters before she came, saying there was not enough room in the house. I made various suggestions which she went along with in words, and which I knew she wouldn't go along with in action. And when she got here I tried to pin her down and asked her to take a room near us and stay for the winter, as she usually does. She went along with it for a while until we had a horrible scene in which I was reminded of all the things that had been given to me, my education, etc. And at the time I was made to feel like an ungrateful daughter; more than feeling ungrateful, I felt fear. I was afraid she would have a stroke or something, and I felt I had to be quiet and let her get it out of her system. . . .

G-M: She is punishing you. It makes me think of my mother-in-law. We've had scenes of the same type, and that's what she would do.

Th.: Punish you if you don't go along with her?

G-M: Yeah—feel hurt and go home. [Pause]

Th.: Are there other reactions to this? [Pause] We started off with an accusation by the group. "Every time I bring up my mother, you all jump off the subject."

E-F: Once in a post-session three or four weeks ago I tried it. I tried it here and didn't get any place. I backed down; it wasn't the group's fault. At any rate, I tried it in the post-session and we discussed it briefly, and then we went on to politics. And I've tried it with H-F over the phone.

[Group conversation and laughter]

M-H: I want to get a recording of that.

[Group laughter]

E-F: So I'm trying it again now.

I-F: I feel that the unfortunate part of it is that you feel guilty about it, and I don't think you should.

E-F: It is unfortunate, but, nevertheless, I do.

B-M (to I-F): Maybe you cannot fully accept E-F's guilt because you cannot accept your own guilt.

[Group conversation and excitement over I-F's lack of acceptance of E-F's guilt as a problem.]

I-F: But if she didn't feel guilty, I think the whole thing would be solved.

D-F: That's just it, I-F, she *is* guilty and you can't see it because you have not yet accepted your own deeper mother feelings.

Th.: How do you feel about it?

A-M: I don't like . . . Why did she invite her for the winter in the first place?

E-F (cynically): That was just the solution, "Tell her not to come," which is ridiculous, because I wanted her to come.

Th.: The "solution" that A-M gave you just now struck you as ridiculous advice.

E-F: Precisely. I think it's an escape. And, furthermore, I'm not capable of doing it emotionally. I can't do it. . . . And I want to be able to be with my mother anyway.

D-F: Nice and close and yet distant as you want it.

E-F: That's right, under my own power.

D-F: Just like my own mother. I like her in small doses.

G-M: I used to want to be with my mother, but I can see now that she just stresses my dependency on her. [Pause]

F-F: Well, if it were my mother, I wouldn't want her around a whole lot either. And it would be just about what my mother would do. If they can't have their way, then they get mad and . . .

A-M: That's exactly what I tried to point out. The fact is—I see it again—the whole thing that E-F points out is the fight between the two gals, herself and her mother for control; the bossing is definitely in my association. I am always sensitive to the idea that the women are concerned with bossing and power, the female neurosis of bossing.

[Group laughter and multiple conversation]

G-M: You have this fight as to who's going to control you, you have that fight with your own mother.

A-M: Yes, definitely, and she'll back off, waiting until she gains . . . material to give me the works. And so I can see that there's just no letting up. I mean the female is going to rule and have the last word. She has to compensate for her physical weakness.

Th.: The group laughed about these comments of A-M, why? Perhaps you all understand, with good humor, the background of why A-M reacts as he does here to the girls in the group.

[Females agree and elaborate]

I-F (to A-M) : Apparently you must have had years and years and years of that struggle with your mother.

B-M : Sure, it's been going on since he's been born, practically.

Th. : In reacting to E-F, A-M thought of his own problems with his domineering mother. Are there any other reactions to E-F? I wonder if anybody felt a certain sense of pride, "I told my mother off!"

H-F : Apparently she doesn't want to be divorced from her mother. It's just that it's a means of reporting progress to the group, that you attained some independence by saying, "Mother, I don't like you around. I want you to leave."

G-M : Well, the moment anybody does anything, somebody always brings up that he does it only to show progress to the group, like E-F's independence.

E-F : What makes you think I'm independent, that I've asserted myself? I feel I've done just the opposite.

I-F : But if she had gone, if she had left your home, and had sought another place to live, and would have spent the winter, you would have felt that you had attained independence of your mother and still have retained her love.

E-F : That's right, that's what I wanted.

I-F : Certainly.

E-F : That to me would be very satisfactory.

[Group conversation]

H-F : I can't.

B-M : What can't you understand?

H-F : I really can't.

G-M : That she's upset by her mother?

H-F : That she doesn't want her mother with her.

E-F : I think that's why H-F can't ever understand . . .

H-F : That you don't want her right with you.

E-F : She thinks this is a horrible rejection of mother.

Th. : If you had your mother alive, you would want her with you.

H-F : Yes.

E-F : She would not be with you. You have your sister, but you don't want her. It's a comparable situation.

Th. : H-F's attitude interests you quite a bit.

E-F : Yes, it does interest me intensely.

Th. : What within yourself?

E-F : She and I have the same problem exactly. And I have the



same solution to it, my mother's solution. And there's nothing I can do about it.

G-M: Why don't you want your mother with you?

E-F: Well, I don't get along with her well.

G-M: What exactly don't you like?

E-F: Well, she tries to tell me what to do.

A-M: Well, that's the same situation I'm in, and the situation anybody who has a mother close by—they never wean themselves from us!

E-F (to A-M): How could you know the female viewpoint without a home with children? How could you know what a woman wants? You say she wants to rule the home. I don't expect you to understand it. I'm not being critical in that sense.

I-F (very warmly): I don't think he's being critical of you. He thinks of your mother and then feels his own problem of a fight for power with his mother.

A-M: Your mother is a problem child to you. So the question is, "Who's going to win?" That's what I'm pointing to. I have the same situation with my mother right now. I mean I left my wife and my mother is completely out of the whole situation. I pushed her right out of it. She didn't have a thing to say about it. I said, "Stay out of the deal; I'm handling it." So little phone calls start to come in here and there. And now she's dug up some dirt from somebody else in the family and called me today, and told me some things about my wife, and told me why she was telling me. The thing that she senses is that I'm weak and will go back to my wife, and she's really giving me material so that I definitely won't do that.

B-M: She used to say before you left your wife that you were not a good husband.

A-M: Now she is telling me that my wife used to run around with niggers and everything else. She's getting this from some place; where she got it, I don't know. But all she's doing is throwing dirt in, reasons for me not to go back, and it will be mother's dominant control which will keep me from doing it. That's my projection.

D-F: It doesn't sound like projection. I remember your saying once, "My mother never liked any of my wives." This was before you left your wife.

A-M: Yes, that's what I say.

[Group conversation]

Th.: Here we had several reactions about mothers. It seems that we all are struggling with a common problem.

H-F: Yes, our dependency and our fear to do things alone.

Th.: Now, what about that?

I-F: I agree with her.

[Group conversation]

Th.: And what is your feeling toward being a parent, having children now, yourself?

I-F: I love him very much, but I'm bewildered by him.

[Group conversation]

E-F: Do you really love him?

[Group conversation]

B-M: You don't say that very happily, "I love him very much." What does that mean to you?

E-F: I can't believe that you do if you rejected him. I can't picture any circumstances . . .

I-F: What do you mean, "rejected him?"

E-F: You're not really accepting the mother role. He's not at your home. I don't know the circumstances. I don't listen because I don't want to hear it. It's so revolting to me.

I-F: Well, what about your mother?

E-F: I'm talking about children, not mothers.

D-F: I don't see that that has anything to do with it.

I-F: Well, E-F, it's so nice for you to sit smugly there, and have an income, and not have to support your own children, and criticize me for putting my son out of my home because I cannot pay the bills and have to go to work.

E-F: I tell you I don't know any of the circumstances. I don't listen because I find it intolerable to let go of your own flesh and blood regardless of the economic circumstances.

B-M: Doesn't your former husband give you alimony and support?

I-F: Certainly not. You think I'd get any support from my daughter?

Th.: In criticizing I-F's mother role, are we not just repeating our critical sentiments about our mothers?

[Pause]

H-F: Personally I had a wonderful relationship with my mother, and the only way I could follow this discussion emotionally is to think of my father, whom I feared like most of you feared your mother.

B-M: I think we've discussed this mother problem enough.

## Therapeutic Use of Historical Material

The emotional tone in the above group discussion of mother-daughter relationships was at times very intense, and the content was not easily forgotten. Several patients attempted to integrate the strong emotional experience felt during this group meeting in their individual sessions, from which the following excerpts are given. It was not until six weeks after the mother discussion that two patients of Group I, namely, E-F and H-F, brought the topic up in each of their individual sessions. Note in the following protocol from H-F's individual session that the process of cognitive integration includes an activation of the historical perspective, which helps the patient to gain a wider perspective of her existing, frightening neurotic tendencies.

### PROTOCOL No. 5: INDIVIDUAL SESSION WITH PATIENT H-F SIX WEEKS AFTER GROUP PROTOCOL, "MOTHER"

H-F: You remember when I could not understand how E-F or A-M or any of them could detest or fear their mothers? Well, E-F and I had a chat the other day—a long one over the phone when my boss was not around. [Smiles broadly]

Therapist: And when I was not around either.

H-F: You? Oh, I see. Yes, E-F and I do talk more freely outside the group. I see what you mean. [Smiles again] Anyway—where was I?—Yes. For over a year now I have never had any understanding whatever about this mother business. I always found a friend in my mother and could not understand how so many in the group have so much trouble with theirs—until that time in the group—you remember? I said that I had that kind of trouble with my father. Since then I talked it all over with E-F, and the funny part of it is that she, herself, E-F I mean, plays "mother" right here in the group. She is the focal point of dispersing news and of evaluating what all the members do. She keeps in touch with everybody between meetings by phone. But there is a big difference between her "mother role" and the kind you get in the family. She is not mistreated by the group and her evaluations are not discredited. She does not use

the information to blame, but to help. [Note discussion of difference between family and associative peer life in Chapter 18, p. 322.]

Th: You are putting E-F in a mother role. Are there other family reminders in the group?

H-F: Sure, there is D-F, who can stand her own mother only in "small doses." Well, she is the big mother figure of the group, but the one that struck me from the first moment I met him in the group was A-M. He is so much like my brother, just as crazy, with all his delusions and suspicions—his "fooling around" with girls. My brother used to disappear for days and weeks. When he came back home, he never said anything, but "Oh, just fooling around, just fooling around"—the same words that A-M uses. Once my brother shackled up with a whore in a bordello. Mother went to beg the girl to send my brother back home. When he finally arrived—the prince—everyone was so happy to see him, regardless of what he had done, but let anything happen to the girls, and we got thrown out of the house. I resented this terribly. Maybe that is why I am so insanely angry at A-M in the group [Note!] . . . he can get away with murder. He can do anything and say anything in the group and *you never stop him!* [Pause] Well, do you? Ah—I can see what you think: "There she goes setting up rejection." Well, maybe, but I have seen you be very nice to A-M even when he behaves abominably and asininely in the group. Yet you pick on me, unless I say something really helpful.

Th.: You feel that A-M can say and do anything, even unhelpful things in the group, things I would not tolerate with you?

H-F: [Smiles] Well? It is so, is it not?

Th.: You experience it so. I think I am quite impartial. I experience it differently, but the important thing is that you can express your experience rather clearly. I wonder whether you can go on with this train of thought. How do you feel about D-F—you called her the big mother? How about her relation to A-M? How do you feel about it?

H-F: You know that I do not like D-F's attention to A-M. How can she see anything in *him*? She thinks he is a nice guy. I know she is fond of him, so with her, too, he can get away with it, while she is very critical of me.

Th.: You experience a partiality in D-F and in me; you talked about it today. When you mentioned that your understanding



of mother relationships is changing, you also mentioned how you resented the partial preference toward your brother over you in your family. Your problem of sharing me and some of the others in the group seems to have a long history?

H-F: I know that I couldn't stand the group for a long time—my feelings of resentment and rejection still come up often—but it really helps me to see how I resented not being included in the privileges my brothers had in my own family. This begins to make sense, for really, why should I feel so intensely rejected at times by the group and by you? At the time I rationalize it completely as justified, but later, especially when I discuss it with E-F or I-F over the phone, or in post-session with G-M, I feel, "Gee, that's absurd, that's crazy!" [Pause—resistance follows this insight, accumulates, and expresses itself.] But I still say that I have a realistic perception about A-M; he can do anything he wants to in the group. . . .

The above protocols exemplify how in group therapy an intensive interest in present life problems stimulates discussions of historical material in private sessions. In a sense every contemporary conflict situation stimulates in the patient a historical perspective concerning similar situations. This type of conversation gives support to the idea that adult neurotics are still suffering acutely from parent-child fixations and dependency problems, and that in the course of therapy they are struggling to achieve the long overdue weaning process. Insight into still present fears of mother domination or guilt over revolt against the mother's domination are sufficient to motivate the individual to overcome this type of personality problem.

Emphasizing the ingrained quality, the long term constancy, of the now disjunctive state of affairs between a patient and his parents may have the effect of overly impressing the patient with the discouraging degree of severity of the neurotic fixation. For many patients it is unnecessary for therapeutic gains to "know" or to believe that they know the remote origins of present disjunctive interpersonal relationships. All that seems necessary, is that the patients themselves perceive and emotionally experience the disjunctive and handicapping nature of these relationships.

## Therapeutic Use of Historical Material

Even though many patients need not (for making therapeutic gains) communicate about presumably originating situations, there is no question about the validity of the observation by Wolf *et al.* (1952) that the therapy group situation is a very suitable setting for the exploration of the past via the road of interpreting present maladjusted relationships as transferences and reactivations. In addition to direct discussions of past life history, the patients' dream reporting takes them, by way of association, easily back to scenes of early family living. Again this is particularly true of those patients who come under the old-fashioned label of conversion hysterics. These patients always see to it that historical aspects are not ignored in the group. They indeed suffer (or do they perhaps enjoy?), as Freud noted over fifty years ago, from "reminiscences."

These patients may give rather shrewd "transference interpretations" without any suggestion from the therapist. They observe keenly the transference nature of *other* patients' reactions to the therapist. In the previous protocol patient H-F could not understand how anyone would not want to be with his mother. This patient, whom we meet again in the next protocol, came from a very large family in which she experienced complete lack of recognition and psychological neglect. The patient always interpreted any hostility other patients, who were only children, such as Patient F-F showed to the therapist as "reactivation."

### PROTOCOL No. 6: REACTIVATION

H-F: You are jealous.

F-F: Jealous of what?

H-F: Don't you know that you're jealous of George [the therapist]?

F-F: [Laughs] It's possible, but I think I have a real beef about him.

H-F: That's what *you* think. You just can't stand his showing any attention to me or to anybody else here. You never learned how to share "papa!"

The historical insight which seems to be so beneficial to certain types of patients may in other cases be actually distasteful,

demoralizing and resistance-evoking. While some patients thoroughly enjoy the rationalization of their present neurosis in terms of the "evil" influences of past figures, others are very disturbed by the historical perspective and show great resistance against it. From a clinical standpoint, we see no reason whatever for destroying a positive past time perspective and replacing it with a negative one. The past time perspective is, in any case, a cognitive mental construction rather than a reflection of actual reality.

It is possible to maintain that at least in some cases of adult neuroses the childhood was in fact experienced by the patient as a happy one, and that the neurosis was produced in a more recent phase of adjustment to severe and conflicting demands of societal living. However this may be, the fact is that the group therapy setting lends itself both to historical and ahistorical frames of reference on the part of the therapist. The ahistorically oriented therapist does not directly reinforce the group's very spontaneous tendency to become historical while the historically oriented therapist may choose to reinforce this frame of reference during the group discussions.

## Chapter 8

### SPONTANEOUS ACTIVITIES: ADVISING AND SOCIALIZING

---

Members of the therapy group spontaneously keep each other informed of the adjustment problems in their marital, sexual, business, and social lives. Sooner or later the majority of the group will notice a certain repetitiveness in the kind of problems that a given patient complains about, and confronts the patient with this observation. If the patient reacts defensively, some of the newer group members may lose their initial attitude of tolerance. At this point sympathy undergoes a metamorphosis in the direction of irritation. A nagging oral aggression becomes typical during this phase of the life of the therapy group.

From this observation it can be seen that many members' reactions to personal problem reports are by no means always "helpful" or even "accepting." As a matter of fact, the modal form of reaction by the group to its members' personal difficulties may be characterized by a complete lack of neutrality. Judging, approving, disapproving, directing, and correcting are the rule, all quite in keeping with directive, nonanalytic, pre-Freudian psychiatry and counseling. I find it helpful to liken this phase of the life of the therapy group to the sentiments prevailing in a courtroom.

#### The Peer Court

The patient reports or confesses, let us say, his latest "run-ins" with his wife or sweetheart or boss. Then he will be closely questioned as to his "true" feelings, the "real," underlying, "deep" motives for his actions and reactions. This will at times be mingled with excited expressions of judgments of "good"



and "bad," of normal or neurotic, of progress or regression, and is generously sprinkled with profferings of psychoanalytic jargon as to the "real," infantile nature of the difficulties. Soon the reporting patient, bewildered by this avalanche of directiveness, assumes a submissive attitude. This is the signal for the group to come forward with a general dose of advice, of "why don't you," and "why didn't you," "try that," and "try this." There is usually a majority and a minority opinion, each giving quite different advice as to what to do in the outside world to lessen the problems by which the reporting patient is confronted.

The therapist never enters this type of group activity except occasionally to remind the group of what it is doing, a reminder which it never accepts. The therapist's reflections are experienced by the group in its advice-giving and directive moods strictly as a "wet blanket," although the particular patient who is on the "hot seat" may be appreciative of such a clarification.

The dynamic significance of advice-giving has been studied quite carefully by a number of group therapists (Durkin, 1953). It would be misleading to assume that this necessarily traumatizes the patient in question. As a matter of fact, the group rarely does anything, and I mean anything, to its own members that is not in some sense emotionally appropriate and gratifying to all concerned. The group life creates its own rituals of interpersonal traffic, and it would be foolish to believe that an activity as popular as directive advice would be continued with its characteristic vigor without those who participate deriving some basic emotional gratification from it. This is obvious in the case of the advisers, but even the advised and directed show by their willingness to take the "hot seat" week after week that they derive some neurotic satisfactions from perhaps submissive, masochistic needs. One can only estimate the strength of emotional gratifications that are derived from being the center of the peer court's attention.

Hysterical patients may engage in very foolish actions between group sessions in order to be able to report these infractions of sanity, and to be properly judged, admonished, and redirected. At any time when patients show an intensive emotional reaction, during or after reporting personal problems, with

a flare-up of physical symptoms or other indications of severe emotional stress, or when they show their tension in the form of intellectual confusion or extremely poor communications (as, for example, in temporary psychotic episodes), the group suddenly and with astounding unanimity of action reverses its mood radically. The peer court becomes a sea of silence; it is no longer in session. It suddenly is no longer able to function upon its basic assumption of being the guardian of the sanity of its members.

Quite abruptly a new basic assumption seems to rule the group. This assumption was labeled by Bion (1951) as "the assumption that it is *not* a group," that it does not exist, that it has lost its structure and is in danger of disintegration altogether. The peers who just a moment ago functioned in the role of strong advisers, backing up their directions with "authority and experience," have abruptly become very frightened. Now, momentarily, the group senses its failure to guard the sanity of its members, and having emotional breakdown within its midst, it seeks the professional leader to take the responsibility for getting them out of the difficulty and relieving the anxiety that they themselves have caused. At that time it is usually only the official therapist who can make the initiatory sympathetic and protective gesture, which not only seems to reassure the acutely anxious or disturbed patient, but like a breath of fresh air revives the group immediately. Then members of the group who just previously were playing the roles of prosecuting and defending attorneys, and listening jurors, now reverse these roles and strengthen the rather explicit but brief sympathetic and accepting gesture of the therapist. In their giving of love and sympathy the group as a rule naturally goes much further in overt expressions than any professional group therapist would, could or should ever do. At such moments the group demonstrates a truly remarkable intensity in its expressions of support.

For the reporting member this demonstration of acceptance gives closure to his catharsis, but the group tension is not yet relieved until some hostility is vented, usually directed against the group therapist or some symbolic representation of him, such as somebody's parents, or the director of the clinic, or psychotherapy in general. After experiencing some frustration, groups

always seem to need a scapegoat for the catharsis of aggression. That the choice of such a scapegoat has no rational connection with the cause of the frustration is obvious. The group therapist is always ready to serve in this function, otherwise the group hostility may turn to a member who does not understand these dynamics and is incapable of absorbing the group's hostility. By drawing the hostility the therapist protects the patients against excessive tension.

After the hostility release, the group tension relaxes, with some jokes and group laughter. The latter, incidentally, can be observed on the electric recording as being more raucous the greater the preceding tension was. After a moment of silence which signifies a group closure, they are ready to undertake a "new" topic, often the problem report of another member. The peer court is again in session, and the judging and correcting soon begin all over again on the next subject. This time perhaps another type of progress is made. This time the center of attention, the reporting member, may show no signs of emotional or intellectual breakdown. He states his traumatic experiences in the outside world, or if he has read psychoanalytic literature, he may talk about his childhood traumata. The form of his presentation always betrays the wish to be evaluated and to be judged, with which the group complies most generously.

The reporting member then defends his actions and his method of coping with the difficult situation as best he can. He seems to enjoy emphasizing the difference between his view of the situation and that of the group, and there is clearly some sort of therapeutic gain in this experience of differentiation. Reporting members soon learn effective techniques of adjusting to group pressures in such a way as to elicit from the group the kind of emotional satisfaction that they unconsciously seek. These adjustment techniques may take a great variety of forms, ranging from formal agreement that almost anything the group suggests has been and is helpful to accusing the group of being impatient, of not understanding, and of "projecting" their own needs into the situation.

As the therapist on occasion interprets these unconscious dynamics, he has the feeling so well described by Bion (1948—

51) of being utterly out of place and just barely tolerated as "a naughty child who doesn't know his manners" because he uncovers the repressed motivational material. And in a way the group's response is realistic, because the total existence, the very life of the advice-giving ritual, depends on the nonawareness of these unconscious motivations. The only point of such an interpretation is to indicate to the group that the therapist has a well-founded hope that the group is also capable of different moods from the one he is making explicit, that he hopes the group eventually can do without the defenses of advice-giving and of "standing trial." Any group therapist who attempts to interfere directly with the advice-giving and advice-seeking ritual, however, would obstruct a natural and spontaneous pulse and life blood of the human group, as it finds expression not only in the therapy group, but also in the court, in the church, in the school, and the like.

### Therapeutic Implications of the Peer Court

From the point of view of simple catharsis and externalization of unconscious masochism and sadism, the peer court phase of the group life is therapeutic to a limited degree. But it would be extremely naïve to believe that a patient may gain integrative insight very often through the peer court's probing and advice-giving. Actually, the result of the group's advice-giving is more typically the same kind of confusion, disappointment, and depression that may follow on the heels of a neurotic acting-out episode, alcoholic or otherwise. Because of the confusing mixture of different peer opinions that are expressed, it would be very surprising if the subject should gain anything except the satisfying of unconscious emotional needs within himself and his peers.

While the immediate value of this type of group activity seems at first insignificant, the indirect and eventual gains from it are considerable. Slavson (1950a) lists the focusing of group members' attention on the problems of others, rather than on their own problems, under the patients' "strategies of escape and displacement." At the same time he notes that this type of



“escape” actually is a method the patient uses to come closer to his own problems:

. . . as the problems of another person are discussed, a particular patient can venture much further in the exploration than when he himself is under consideration. He may be strengthened through identification until he is able to admit the relevance of the discussion to himself. Sometimes a patient presses an especially painful subject with a fellow member because he really seeks to clarify it within himself. Thus each can use the others in the grist of his own therapy. Such strategies are among the major advantages of a group, for, through exploring the difficulty of another and identifying with him, each evolves insight into his own.

Because his real emotional needs are *not* satisfied by catering to superficial dependency needs, the advised patient's unconscious needs really suffer strong frustration. This results in increased hostility, which will often be directed toward the therapist. A strong “negative transference” to the total group situation and to the therapist may then be one result, which the therapist must understand as the neurotic acting-out of the peer court.

The therapeutic management of the peer court atmosphere involves the structuring of the patient's interest in self-observation and of the projective nature of advice-giving. It is easy for the therapist to demonstrate to the group the fact that each member has certain “pet” types of advice to give. Usually the subjects for the advice-giving are certain members, while others do not excite the interest of specific advisers.

That advice-giving constitutes a clever defense against self-analysis can be deduced from the fact that even after it becomes obvious to a group that the content of the guidance work and the advice-giving of a particular member is a clear projection of the adviser's own emotional problems, the adviser tries for a long time to defend the content and direction of his guidance work along moralistic, “scientifically psychological” and logically rationalized grounds. In an effective therapy group, however, the projective nature of the advice-giving is eventually uncovered and the advice-giving reduced in intensity and in quantity. It may even disappear for several weeks in succession.

Meanwhile, it is interesting to note the example of one person in a group who wishes to appear as a natural choice for normal

leadership and who will carefully see to it that his advisory opinions have strong bases in reality, that they are supported by logic and general common sense. Such advisers project their need for dominance and their fear of spontaneity by their rational and diplomatic form of advice-giving. Others, who have unconscious problems of masculine potency, tend to center their advice in the direction of recommending to others incisive and strong action, and economic and/or moral "independence." Those who have problems in accepting love and dependency will also project their needs by trying to push others in the direction of obtaining fantastic levels of "freedom." After some time, if the therapist succeeds in helping the group toward graduation into a work group culture, everyone takes it for granted that any advice-giving tells them more about the adviser than the advisee, and that it has no other purpose that should be taken seriously by the group.

The group therapist, Durkin (1948), has made some very constructive suggestions concerning a role technique for the group therapist. It involves setting up as a model his curiosity regarding the personal, subjective reasons for the kind of advice given by the adviser. Durkin points out that the group will then follow this model. In all this the author would give emphasis to an additional point omitted by Durkin, namely, that even when the content of the advice has no projective significance, the emotional experience of just giving advice, that is, of dominating and correcting, carries, so to speak, an externalization of unconscious motivation.

Older patients help to show newer ones that their advice actually constitutes directing others into behavior that would facilitate the mastery of the adviser's, not the advisee's, emotional problems. If the therapist reinforces this type of interpretive interest about advice-giving in the group, the group soon will, as a matter of form and ritual, follow up an advice-giving round by discussing with each other what within themselves made them offer the advice, and what within themselves made them choose that particular person for an advisee and that particular problem as an object of interest. With such attention to the advice-giving activity, the group atmosphere changes, and the group life be-

comes less and less occupied with reporting problems from the outside and with giving advice on handling problems on the outside. A shift seems to occur in the group culture from the peer court phase to a self-perceptive phase (themes 15 and 16).

### The Group's Rejection of Emotional Disorder

All experienced group therapists have been curious about the ambivalence of groups toward their members which expresses itself in a constant shifting from an attitude of acceptance of patients by patients to unmistakable evidences of emotional rejection of each other as *patients*. As a matter of fact, it must be said that no one in a new group, other than the trained, official therapist, can be relied upon to have reached a point where he can accept realistically the evidences of emotional disorder and its serious implications. If one realizes from experience with the training of psychotherapists how hard it is even for the trainee to accept the reality of emotional disorders, one should not be surprised that not one of the patients in group therapy *initially* wishes to acknowledge the presence of compulsions, let alone other more subtle forms of irrational behavior.

In the rather stubborn refusal to accept serious disorder lie, paradoxically enough, some of the difficulties as well as the advantages of group psychotherapy as a treatment method. It is really quite amazing and very interesting from a scientific standpoint that a group of disordered personalities has such a force or drive toward sanity and health that they are absolutely intolerant of its opposite, even though they themselves are afflicted with it. While this creates management problems for the therapist, and, of course, considerable anxiety for some patients, it at the same time makes group therapy possible. The group always is united in this respect: it will make every effort as a group in a concerted unified action to "push" anyone of its membership out of neurosis into normalcy. Understanding this fact clarifies the simultaneous presence of advice-giving, advice-taking and resenting advice, one of the many paradoxes in the life of the therapy group so puzzling to the newcomer in this field.



Resistance is often an expression of the group's intolerance for the illness of its members and its impatience with the slowness of the psychotherapeutic process. Even in the most advanced and well-functioning, work-minded therapy groups, hardly a meeting passes without someone's implying that group therapy is "no good." One can look at this as presenting "difficulties in management," but I rather think of this so-called "resistance" as the expression of a very primitive curative force in the direction of normality and health. In the tendency to deny serious degrees of personal difficulty lies one of the basic motivations for advice-giving. The method is naïve, of course, but the goal is of universal value and is shared by everybody. This guidance work of the patients, while methodologically paradoxical, is such a universally popular tendency inside as well as outside the therapy group that it must provide some popular gratifications.

The most obvious gratification gained from advice-giving has been recognized in connection with the analysis of narcissistic countertransference reactions on the part of analysts. The over-zealous wish to heal and improve another has been described by Freud (1933) as a derivative of underlying sadism. Since the need for sadistic outlets is strong in neurotic patients, Freud's suggestion seems a reasonable explanation of the unconscious functions of advice-giving. Freud contrasted this unhealthy, sadistic motivation underlying curing and advising with the attitude which he analyzed as being motivated by a scientific interest in the nature of "living pathology," and recommended this attitude as the best frame of reference for a psychotherapist.

Powdermaker and Frank (1953) have suggested three motives for advice-giving which seem specifically to apply to group therapy participants. According to these observers, patients will advise each other to satisfy the following three needs of their own: (1) to keep attention away from their own problems, (2) to assert superiority to the doctor by trying to show him what he should be doing, and (3) to conceal hostility and contempt by apparent helpfulness and consideration, which is a form of sadism.

In addition to individual neurotic sadism, the presence of even a more primitive tendency suggests itself. It is a common observation in animal groups that healthy animals will attack mem-



bers of their herd or flock who show signs of disorder. It seems that, instinctively, the herd does not tolerate pathological deviation and indeed it is not necessary to go far for examples, for it is evident even in the way our own civilized culture treats its emotionally and mentally ill (cf. Deutsch, 1948). The sadism that underlies advice-giving seems therefore to be more an expression of a universal instinctual tendency than it is of a specific symptom of individual neurosis. In any case, whether of ontogenetic or phylogenetic primitivity, the tendency is strong.

The above discussion of the peer court and of the therapy group's rejection of disorder will help the reader to get the flavor of what is meant by "freedom" and "permissiveness" in group therapy. It should be fairly clear that "permissiveness" and "freedom" refer to freedom to deal with each other, but often this very freedom results in attempts at controlling and restricting interpersonal contact and traffic. As we shall see in our discussion of neurotic pairing the therapy group is, for example, by no means libertinistic in the sexual area; rather, it is censoring and discriminative.

In the author's experience, neurotics are much less tolerant of neurotic behavior than are non-neurotics. The better adjusted person is not made so anxious by examples of neurotic, disjunctive behavior; he can "laugh it off." The neurotic patient in the therapy group who tries to wean himself from disjunctive patterns is a very keen observer of these behavior patterns in others. He is strongly affected emotionally by them and fears pathogenic contagion. This is one reason why he uses his freedom of expression to project his rather strong intolerance of neurosis which hides his wish to be rid of his own neurosis. It is almost tragicomic how the reaction of an established therapy group to a newcomer is mainly "disappointment" when it becomes clear that the newcomer is neurotic, even though the group members in voting and selecting him were "fully aware" of his neurosis.

One of the constructive therapeutic gains unique to the group therapy medium derives from this paradoxical situation. When a group experiences emotionally the neurotic behavior manifestations of others, as well as their own, they gain a deep re-

spect for and appreciation of mental health and conjunctive attitudes. Learning through experience the tension-evoking, disjunctive effects of neurotic manifestations, observing with their own eyes how neurotics make life difficult for themselves and others, seems to trigger an intensive desire to behave differently. This is a very important therapeutic step.

Dollard and Miller (1950) and other depth therapists have pointed out that the neurotic patient comes to therapy without knowing the nature of the difficulties which produce his symptoms. The patient has no idea how he contributes toward making his own life and the lives of his compeers not only difficult, but in the more severe cases almost unbearable. Gradually, before the peer court of advisers, observers, and judges, the disjunctive effects of his personality begin to dawn on him. Then it is of crucial significance that he be helped to overcome a deep resistance against group therapy, for as soon as the patients have progressed to a point where they begin to sense the disjunctive effects of their personalities on others, and thus the isolating and punishing effects on themselves, they tend to shy from further work with the group. Many of our "dropouts" occur at this point.

At this time the individual session is indispensable in working through such resistance. These individual sessions are devoted exclusively to the theme: "Yes, you do show your worst side in the group. That is what it is for. You can see what makes your life difficult." Reassurance is given that the group in many ways stimulates an exaggeration of neurotic behavior because of its uninhibiting influence, and that there is a great difference between behaving in the "neurosis-inviting" environment of the therapy group and in the "control-inviting" social situations of everyday life. This distinction is one of the reasons why in our regime emphasis is given to a boundary between the therapeutic microcommunity and the macrocommunity outside.

The group's judging and advising activities have to do with two related therapeutic processes. First, the advice contains information previously unattended to concerning interpersonal effects that the advisee exhibits in his surroundings. Secondly, the advice contains information for the advising person as a projec-

tion of his own intrapsychic motivational structure. Thus, even though the unconscious motivation of the group, which underlies its forming a peer court, may have a primitive, hostile, sadistic or fearful element in it, experience shows that the group therapist can help the individual patients make therapeutic use of this advice-giving and judging tendency.

### Transition from the Advice-Giving Phase

Gradually, through the help of the therapist, the group becomes self-conscious, literally self-conscious, of its advisory functions, and of the rhythm of selecting one member at a time to be its focus of attention. In the language of the patients, this means that each member experiences being alternately on the "hot seat" as a subject of the "analytic work" of the group and on the jury doing the judging and analyzing. Once the group is fully aware of this process, or at least when the majority in a continuous group is fully aware of this process, the group therapist can reinforce the idea that it would be helpful for the advisers to perceive what within themselves makes them give the advice that is forthcoming, which shifts the focal attention from the advisee to the adviser and also gives the group some feeling about the unconscious personal motivations for advice-giving.

In group therapy it is important to avoid the type of group attitude or group culture which makes advice-giving always a projective or pathological affair. In other words, it is important to avoid the idea that *all* advice-giving is simply a projective affair made for the clinical or psychoneurotic gain of the adviser, and that it never has any value to the advisees. At times, the perceptions are quite accurate and give evidence of considerable insight into the disjunctive behavior patterns of the other person. At other times the advice-giving has nothing to do with either the adviser or the advisee and is simply a symbolic expression of certain unconscious group situational feelings. Feelings that Alpha may have about Beta are actually not directly expressed to Beta but are expressed toward Gamma in advice from Alpha to Gamma. In other words, the situational interpersonal dynamics may determine advising. Trying to impress a third or a fourth



party is frequently the real motivation for some of the advice-giving.

The realistic part of perception that is contained in the peer court procedure can be gradually expanded to a point where a work group learns to become quite "sharp" with respect to its members' habitual tendencies that make communication with these members difficult. In other words, the peer court of judging and advising shifts gradually into a staff conference type of work group in which the group forms group opinions, group perceptions, concerning the behavior of each of its members, and learns to communicate them to such members. The therapist in this process tends to facilitate the process of group consensus-forming by giving closure and weight to those perceptions which seem to be fairly unanimous. As the group progresses away from the phase of the peer court, it exhibits fewer and fewer instances of advice-giving and concentrates more and more on attempting to help the patient to see how he affects other people, how he affects the group.

### Reporting Experiences Following Advice

Groups frequently consider the advice given to another patient by a majority as a "group mission," or assignment. The advisees seem to experience it as such, even though interestingly enough, the supposed "mission" is of no logical interest to the group, but is usually some personal problem outside the group. An example would be the group's advice to a shy patient to go out and assert himself in the collection of an overdue debt. The present theme constitutes the advisee's reporting his experiences in following out the group's assignment.

While by far the majority of these reports contain very thinly veiled criticisms of the group, which serves also as the scapegoat for any failure to achieve the goal illogically assumed to have been created by the group, there are many instances in which patients triumphantly report "success." These latter reports are termed by the group "progress reports." These progress reports are much less defensive than the failure reports and they are also more carefully selected. Groups, while very happy to



receive progress reports, are quite skeptical concerning them and tend to grill the reporter to ascertain the reality of the progress and its meaning. Not infrequently, then, what a patient intended to be a progress report turns out to be a further instance of neurotic distortion. This occurs in a group atmosphere similar to the peer court of advisers and judges with which the reader is already familiar.

By studying the choice of content in progress reports, the therapist gains cues as to the quality of cognitive structure a patient exhibits concerning (a) his own goals for therapy, and (b) his perception of the group's goals in therapy. When the therapist finds, for example, that the content of the "progress reports" remains on a superficial, nonpsychological level, he should seriously consider the need for expert consultation on what factors in dynamic process of the therapy group reinforce the patients' perceptions of therapy goals as superficial or nonpsychological. When on the other hand, the topics of progress reports deal with attempts at mastery in self-other relationships or in integrative processes or when these topics are generally indicative of real movement along clinically valid, therapeutic lines, the therapist can feel confident that the therapy group is developing toward, or has actually reached, a therapeutically efficient work phase.

### Analysis of Social Activities (Theme 13)

Following the office meetings our sample groups hold social "post-sessions" without the presence of the therapist. In these social gatherings four processes of particular clinical interest can be observed: (1) the therapeutic reinforcement of insight gained in the work session of the group, (2) the preparation to deal with difficult and resistance-evoking material through the development of social alliances, (3) the opportunity to release pent-up tensions that were instigated but remained unreleased in the clinical work session, and (4) the provision of experiential data on neurotic set-up (acted-out transference) behavior for later analysis.

In social gatherings patients will bring up again and again that which has "hit home," that which has touched their egos

deeply in a preceding office session. In the social sessions the substructure of the group is different. There is more pairing and subgrouping. In most post-sessions two or three patients will communicate their personal impressions in an intensive, emotionally involved and intimate way. Detailed examination of conflicts that were only briefly sensed in the office meeting may be the topic; briefly glimpsed insights are reinforced and integrated.

For the new patient, the post-session frequently is the stage on which he feels free first to express and communicate his own feelings which he is afraid to bring out in the limelight of the office sessions. The pairing dynamics of the social post-sessions make it possible, so to speak, to try out free communication first with one or two members. If found successful, such communications then need not further be suppressed and can be tried on the total group at the office meetings.

Patients who are afraid to work through certain aspects of their motivational structure in the office meetings are reported by others to be working on these problems with one or two members during the "social" post-sessions. The member chosen as the co-therapist is usually one with whom all threats in the relationship have been worked through. In this manner, older, experienced group therapy participants gradually develop their own "private therapist." A study of *whom* they choose gives the therapist valuable clues as to the nature of the needs most acute in the participants. By confiding, especially in one co-therapist member, coalition pairing is strengthened, which eventually leads to an easy revealing of the erstwhile anxiety-evoking material before the total group. The coalition partners usually do not make completely neurotic use of such co-therapeutic relationships, but help each other to bring difficult and confusing emotions to the attention of the total group. But this does not occur until, through much contact, the coalition pair has had a chance to work through threatening materials. Undoubtedly, in some cases, this is used as a drainage and resistance, and one of the roles of the therapist is to help the group realize the possible resistive significance of the socialization. In our experience, we have found groups remarkably understanding of the possibility

of contraindications of social involvement, when clinical work is hampered rather than facilitated by it.

The social group structure, however, is not limited to co-therapeutic pairing. Frequently the social functions involve the group as a whole, and not just pairs. The group may act as a whole to release pent-up hostility, toward the therapist, toward psychotherapy, the macrocommunity, and themselves.

From a clinical standpoint, we would emphasize the point that the post-session, being more intensively ego-oriented, must be part of the therapist's observational field, even though he does not participate in it. His influence may make the difference between the use of social activities to strengthen resistance and defenses, as against their becoming a protherapeutic occasion.

From the standpoint of affect learning, the process of socializing mediates many emotional experiences not resolved in the office meetings. Regularly eating the evening meal together is a good example. The intimate contact resulting from sharing their meal helps the patients to mend conflicting feelings aroused by an intensive office discussion.

Below is an excerpt from a protocol of a discussion of a party. Sample Group I gave a birthday party for F-F at the home of a member, E-F.

#### PROTOCOL NO. 7: EXAMPLE OF THEME 13— DISCUSSION OF A BIRTHDAY PARTY

B-M: I am curious why I felt so swell, so friendly and talkative.

I was a different guy. I know I can say "it was the alcohol," but usually I get even more glum with drinks.

C-M: It couldn't be the alcohol, because you were quite elated from the very beginning of the party before you had anything to drink.

B-M: Touché. I know it. I'd like to know what made me so happy. I wish I could feel that way more often. [Turning to G-M] I even felt friendly toward you.

[Group laughter, followed by silence]

Therapist (to Group): Did you all feel this friendliness and relaxation in B-M at the party?

[Several patients confirm and elaborate]

H-F: What comes to my mind is that you were playing host.

E-F: Yes, I asked him to.

B-M: Yes, I enjoyed doing that.

Th.: Do you feel the same way about playing host at home?

B-M: Oh, God no! I feel *there* as if I do *not* belong.

Th.: In your own home you feel as if you do not belong, but at the party in E-F's home you felt differently.

B-M: [Laughs] I know there is something screwy.

Th.: Perhaps the group can help B-M understand himself more deeply in this situation. Are there any more speculations?

G-M: I would go further along H-F's line.

H-F: I actually did go further myself that very evening when you, B-M, were so nice to me. Then I wondered what the hell had happened to you. And I felt, "he has replaced the head of the house." He has taken over the house and E-F, the wife. This you loved.

B-M: That could be.

Th.: What comes to your mind now?

B-M: [Pause] It's silly. My father telling me what to do.  
[Laughs]

Th.: Can you go on?

B-M: Didn't want to mow the lawn. Didn't ever want to do anything the old man demanded because it never was right—never pleased him.

E-F (who in her interest of having her party further discussed but *not* "analyzed" illustrates an anticlinical, social attitude): B-M, you sure are getting away from the party.

Th.: I feel that his associations here are right on the subject of his feelings about your party, E-F.

E-F: Oh? How? I don't see it because I am anxious about hearing more.

C-M: What do you want to hear more about?

E-F: How B-M felt when my husband came home.

[Long pause]

Th.: I have the feeling that you, E-F, and the group, have brought out something helpful to B-M. If we try to put the various associations together, what does it say? [Long pause] I have the feeling that something important has been brought out and yet the group does not want me to label or analyze it further.

[Brief pause. B-M, H-F, F-F, and E-F think Th. is wrong; they want him to say what he thinks is helpful. C-M and G-M have tangential attitudes.]



Th.: It seems that the associations show that B-M is *still* fighting his father in the form of competing with husbands for a wife's happiness. This fight is stimulating to him, while at home where there is no occasion to work out this interest he is in most low spirits. Also, I felt that E-F is recognizing that she is emotionally affected by this competitive interest of B-M's and really participates in it. How do you all feel about this?

The above protocol excerpt of a discussion by sample Group I of their experiences during a social party illustrates how, especially through the therapist's leading interest, advanced group members (such as B-M) can and do make clinical, analytic use of social experiences, even when newer patients (such as E-F) would like to keep things on a purely social level. Thus, social meetings without the therapist may serve only as an "acting-out stage" for the new member, while for the advanced member they also serve as a reality-testing ground, enabling participants to make helpful self-other observations and insightful discriminations. The protocol also illustrates the occasionally necessary active, firm, almost intruding clinical attitude of the therapist who did *not* go along with E-F's almost purely social, acting-out interest in the party, but reinforced B-M's and H-F's clinical and interpretive interests.

### Socializing as Anxiety Reduction and Interpersonal Mending

The urge of patients to socialize seems to be based on a need created by the intensive psychotherapy process itself in the following way: Participation in intensive group psychotherapy would, without socialization, instigate two forms of anxiety and tension which the social meetings counteract or release. First, getting together without the doctor-leader lifts the weight of authority and reduces anxiety concerning dependency on him. This makes the often unavoidable transference neurosis more bearable. Secondly, the office sessions expose, through the group's self-analytical work, many weak spots and psychopathological, disjunctive tendencies in every patient. This naturally arouses great anxiety and might severely intensify resistances,

were it not for the possibility for each patient to find out, during the social meetings, that even after full clinical exposure of his "worst self," he is socially acceptable. Social interactions thus counteract clinically undesirable forms of resistance due to the anxiety evoked by self-perceptions of disjunctive, interpersonal behavior and emotional pathology. All group therapy participants realize this reassuring and supporting feature of socializing and are naturally drawn to it because they need it.

In considering socialization as a tension reduction procedure, we are not unaware of the very real possibilities pointed out by Bion (1948-51) that patients may make use of the group for the gratification of emotional needs and that this gratification can, when it remains unrecognized and unanalyzed, spoil the clinical or what Bion calls "work" atmosphere of therapy groups. On the other hand, too much of a contrast seems to have been made between the gratification of emotional needs and a type of behavior that is supposed to be "clinical," as if the two are mutually exclusive entities.

An interesting and spontaneously evolved form of social patient-patient contact and influence occurs over the telephone. Most group therapy patients, especially those whose groups meet only once a week, utilize the telephone to maintain contact with each other during the rest of the long week between meetings. But contact maintenance is not the only reason, for groups which meet more frequently also use the telephone. It seems that, in the words of one patient, "I can't tell you about yourself to your face, but I can tell you on the telephone." This was said by one female patient to another, who she felt behaved like a Jezebel, a Salome and a siren at the last group session. Apparently many of the tensions evoked in the group sessions and left unrelieved because of an inability to formulate them or a fear of communicating them are thus relieved.

Over the telephone the fear of expression seems lower for the sender of a critical message, and the tolerance and acceptance on the part of the receiver of the message seem to be considerably higher. The absence of physical nearness and the factor of delay in reaction, which help the patient to look at the previously threatening event with greater clarity, both seem to make possible the

exchange of messages over the telephone which were too threatening to exchange *in situ*. Telephoning, like the post-session, is a mending device for disjunctive emotions aroused in the actual clinical therapy session.

In order to have a group therapy culture in which the conflict between free emotional expression and low anxiety evocation can be reduced, the group must be left free to find several ways to reduce the anxiety which is invariably aroused when emotions are freely expressed between neurotic patients. It can be noticed that those individuals who will "work on each other" in the social post-session and over the telephone are those who have been particularly "clinical" with each other in the preceding office session. The explanation of mending the contacts which were threatened by analytical remarks seems to fit these observations.

Patients have the need to release, through reassuring social contact, anxiety and guilt caused by the analysis of neurotic behavior patterns in others. But the more advanced a patient is in group therapy, the less does he need to fear that his frank discussions in the therapy group are necessarily disjunctive, and the less will he be inclined to use the post-sessions for mending. The graduating patient, who feels very natural and secure in the therapy group, as a forerunner to improved feelings of security in the larger community, very definitely socializes less with other patients. Mere social interest in co-patients is a passing phase in well-managed therapy groups.

### Neurotic "Dovetailing" During Social Contacts

There is a tendency, especially observable in new or less cohesive groups, to neglect to bring under clinical scrutiny extra-office social meetings. Poorly managed groups with low therapy-work morale and low over-all group cohesiveness rarely function as a unit in social post-sessions. Although meeting together physically, such groups communicate primarily in subgroups of pairs. In this way they effectively avoid the formation of a total group, or a majority consensus. Since the major vehicle of effective interpretation and reality reflection is majority consensus or sanction, the avoidance of its formation, made possible



by the absence of the therapist plus the condition of low cohesiveness, makes any clinical observation and analysis on the spot impossible. As a result "acting out," or what we prefer to call neurotic interpersonal "dovetailing" occurs unchecked and unanalyzed.

Counter-transferences, i.e., neurosis-reinforcing reactions between members, *if and when realistically analyzed*, provide grist for the therapeutic mill, but when they occur in the coalitions and pairing between patients without either of the participants or the total group taking an analytic look at themselves, the effect may well be a retardation of therapeutic progress for all involved. Segmented neurotic pairings and coalitions which fail to present themselves for "study" by the total group are the Achilles heel of group psychotherapy. As a form of resistance they are analogous to the attempts of new patients to involve their therapists in individual treatment in such a way that a clinical and realistic evaluation of the patient's neurotic behavior and thought patterns is made difficult or impossible. We shall discuss "neurotic pairings" in a later section.

### "Social Incognito" and "Acting Out"

Clinical management of the natural tendency of emotionally disturbed patients to socialize with and to seek further support from each other outside the official clinical meetings is a controversial point among group therapists. Most group therapists accept their patients' socializing needs, but few make it an official part of the clinical program as we do. Classically oriented psychoanalysts see in socializing outside the therapeutic setting only obstruction to the therapeutic process. These colleagues forbid their patients to get together without the therapist. This prohibition has been termed the "principle of the social incognito," and various rationalizations for it have been advanced.

Sherman and Lindt (1952) have argued that without the enforcement of the "social incognito" taboo, "acting out may often significantly interfere with the therapeutic progress." On the other hand, Lindt and Sherman, Wolf (1949-50), Bry (1953), and others agree that . . . "acting out is the soul and



heart of group therapy treatment . . .” These authors distinguish between therapeutically productive acting-out patterns during the group’s office meetings and therapeutically unproductive or objectionable acting-out patterns outside the office meetings. They like to see the acting out only in situations in which it can be directly perceived by all members, and especially by the therapist.

While we agree with this theme, our own experience does not support a policy of restricting patients arbitrarily from meeting each other. Our groups always develop a custom of sharing and communicating all interpersonal affairs. Open group discussions of *all* social activities between patients outside the office setting usually prevent any misuse of acting out. In our regime, any socializing activity is shared with the group and all feelings attending extragroup operations are discussed. Our patients consider socializing as part of the therapeutic program. Prohibitions from the therapist are unnecessary in view of the self-regulating forces in therapy groups to make progress toward the common goal of rehabilitation. We have found that it is possible to make therapeutic use of *all* “acting-out behavior,” whether it occurs in social meetings or in the office visits.

In our intensive group therapy program, which goes beyond the free-association level of communication into a perceptual analysis of actual here-and-now repetitive contact patterns, the patients’ progress is dependent upon actual social experiences. Acting-out behavior patterns, observed in the social post-sessions, are compared with behavior patterns observed in the same patient when the therapist is present. This comparison provides a set of cues essential to differentiate the various disjunctive patterns of the patient. Should the therapist forbid socialization, the possibility of comparing behavior in the official therapeutic milieu and in the more social milieus is impossible. Thus, an important vehicle for therapeutic work is not available. Furthermore, when extraclinical meetings which tend to strengthen member-member cohesiveness are excluded, the group is unconsciously more dependent upon the therapist for keeping it cohesive. The main cohesive bond in such a weak group can then only be what Freud (1922a) insightfully labeled the common identification

with the leader around whom they rally. However, when socialization is encouraged under the provision of shared communication, the group provides strong member-member identification and a group-centered, rather than an authority-centered, atmosphere; it becomes a peer group.

### Damage Resulting From Acting Out

Another argument against socialization is given on the basis that socialization may lead to "irreversibly destructive effects on each other" (Sherman & Lindt, 1952). There is no disagreement among therapists that group therapists have the responsibility to reduce what hazards may be inherent in being neurotic. The methods by which this responsibility is best fulfilled, however, are by no means clear or agreed upon. In individual psychoanalysis this responsibility cannot possibly be fulfilled within the therapeutic setting. There the patient is protected only from acting out with the therapist. Patients undergoing psychoanalysis are well known to act out emotional tendencies mobilized in the analytic process in extratherapeutic settings where it is really dangerous to do so. In group therapy, we protect the patient from dangerous acting out outside the therapy group through socialization within the group, which siphons the neurotic tensions in a safe place. Socializing broadens the safe ground for the absorption of neurotic acting-out tendencies within the framework of therapeutic analysis. Our patients have remarked frequently that they find this feature of group therapy very helpful in an ameliorative way. "If I can be neurotic in the group, I can control myself better at home and at work," one patient (T-M in Group II) recently remarked.

Through socializing, patients can, so to speak, release in the group certain free expressions of neurotic interests that would, if they were expressed in more realistic social milieus, lead to punitive consequences. The free discussion of their hostile and sexual tendencies, and their giving comfort to each other with respect to their fears that their neurotic tendencies might break through compulsively in settings in which they really *can* hurt

others and themselves, helps to prevent these very occurrences of which they are afraid.

To use the therapist's responsibility to protect patients from irreversible damage which they might cause each other as an argument against all socializing and for the "social incognito" is like throwing out the baby with the bath. Through socializing, much anxiety release and catharsis take place. During the proper development of a therapeutic work-culture, all patients soon enough develop a group standard which frowns upon serious neurotic exploitations of each other.

An advanced group by the rule of reporting such tendencies and exchanging experiences about all extraclinical meetings takes care of the possibility that the group may not be informed about such activities, and once a freely communicative community is informed of wrongdoing, it can be relied upon thoroughly to remove the danger. In our years of experience with therapy groups, who socialize rather heavily, a damaging sort of acting out has very rarely occurred. Even then the damage is not "irreversible." In one such case, a female patient, who acted out her sexual attraction to a psychopath, learned from this experience to put sex into a more realistic perspective and had a host of other insights. In all cases, destructive experiences were eventually worked through and much benefit was obtained from clarifying the motives concerning the neurotic acting out that was inevitable at that time.

### **Differentiation of Social Reality-Friends from Therapy-Friends**

Since many of the social extraclinical meetings between members of psychotherapy groups are in the nature of acting-out behavior and dovetailing attempts within neurotic set-up operations, experienced patients have worked out a very effective form of protection from possible real damaging effects of neurotic involvements with each other. They tend to keep their real social field away from their contacts with the therapy group. In our groups, the term "being social" has the restricted meaning of



meeting with group members without the therapist. This does not mean including members of the therapy group in the natural field of the social and occupational life of the patient.

In experienced groups, the maintenance of and respect for a boundary separating the realistic social life sphere from the co-therapeutic social life of the therapy group becomes an explicit culture value, deviations from which are tolerated only under such emergency conditions as unemployment and serious illness. That such a boundary between the social field and contacts in the therapy group is, on the whole, effectively maintained is reflected by the absence of "intermarriages" and of work or other partnerships among patients in our regime. This is not to imply that ex-patients deliberately avoid each other or fail to maintain rather warm feelings of camaraderie for each other. Wherever the natural condition of the social environment has been such as to keep ex-patients in contact, these contacts are reported to have a special, security-rendering flavor.

The continued maintenance of the boundary between the therapy group and the real social field depends on a system of continuous grouping by which older patients who, by experience, have learned the wisdom of such boundary maintenance, and who have fully accepted the fact that the social activities within the groups are largely "neurotic," will transmit these boundary mores to the new, as yet inexperienced members. All advanced patients soon develop a self-limiting discipline about keeping their social field and their therapy field separated. The following excerpt by a patient of Group II (K-F) expresses the feelings of reserve which patients develop about becoming realistically involved in each other's social life.

PROTOCOL No. 8: "DO NOT MIX THERAPY  
WITH SOCIAL LIFE"

It has been my feeling [K-F said] that one can have meaningful relationships with other members of one's group, and yet find that these particular relationships have no place *outside* the confines of the group life. In the rarefied atmosphere of the group, relationships spring into being by the mere fact of one's contributing presence. The varied backgrounds and age differences of the respec-



tive members fade away into relative unimportance. One is aware only of how one *feels* about the other person.

The group member runs into difficulty when he tries to fit these relationships into the main stream of his life. Here he has to consider the standards of his social and cultural grouping; he has to consider the fact of his family situation, and the influence such a relationship will have upon it. All the factors that were relatively unimportant within the group structure suddenly take on significance.

If the member forces his inner group relationship outside the group in spite of all the difficulties of integration, then it seems to me that the member is merely using the relationship for his own neurotic purposes. Ultimately, under these circumstances, the group relationship must disintegrate because its use has been pressed beyond realistic limits.

The above opinion expressed by a patient with over three hundred group therapy sessions (approximately 1,200 hours of contact) illustrates the point that experienced patients learn to set limits to the extent in which they will involve each other in their "natural" social life. Thus, under proper management, socializing does *not* mean that the boundaries between therapy social life and natural social life are given up. Not at all! The boundary between the interpersonal realities of everyday life and the peculiarities of psychotherapeutic contact is respected in order to preserve the unique opportunity afforded by associations in the therapy group for self-analysis, which the ordinary social interdependence in actual family, marital, work, and neighborhood social relations actually excludes. But this boundary need not be narrowly drawn around the "official" clinical associations before the observing eye of the therapist. In our regime, patients are encouraged to avoid overlapping memberships by not introducing their real life associates to their associates in the therapy group. Practical considerations of professional-like discretion alone provide a sufficient initial rationale to make this procedure acceptable to all newcomers.

When members are already socially involved with each other in reality, any therapy regime which involves self-exposure is extremely difficult and slow in progress. In the case of living or working together, the neurotic caution about self-exposure is

reinforced by the realistic danger that such knowledge will be used or misused, even inadvertently, to influence others who make realistic decisions affecting the person in question. Self-analytical processes would be resisted by those who realistically are socially interdependent and who could damage each others' natural social field.

The above observations serve to clarify the need for the therapist to help the group to create a miniature group culture with definite boundaries in relation to the macrocommunity. The maintenance of such a boundary can, of course, be made too difficult or the boundary can be made impenetrable by too much realistic social involvement. But to say that within such a microcommunity socializing necessarily destroys self-analytic and other therapeutic processes is an unwarranted generalization from a problem which is specific to situations in which the realistic-natural life spaces of the patients overlap to a substantial extent. The generalization does not apply when socializing is confined to the membership of the therapy group.

## Chapter 9

### CLINICALLY INSTIGATED PROJECTIVE COMMUNICATIONS: DREAMS AND DRAWINGS

---

In almost every session at least one patient tells the group a dream of interest to him. The nature of the group's response to a dream report varies greatly, depending upon many factors. According to Wolf (1949-50) the group setting is a favorable milieu for dream reporting and analysis. Wolf encourages his therapy groups to tell dreams and to express freely "fanciful speculations about one another's products." Wolf stresses the rapport-cementing effect between members as a result of reporting dreams and bringing up associations. Our own experience substantiates Wolf's observation that reporting dreams is "an indirect approach which engages the unwary." Patients are less resistive to reporting dream material, the meaning of which they are unaware, since it is "safely" secured in symbolic form. Yet actually, dreams are the most economic way of revealing essential unconscious conflicts. Since groups learn this fact very quickly, they maintain a keen interest in dream reports.

Of particular interest here are dreams which involve other members of the group, either as symbols or as "analysts." In group therapy dream reporting and dream analysis have a communicative function, as do projective drawings. The greater freedom to express feelings verbally, plus the pictorial fantasy materials from dreams and drawings, results in a process which is not unlike dreaming. When everyone in the therapy group engages, together, in an exchange of projective fantasies, the atmosphere takes on an unrealistic and symbolic quality. Because the group life itself takes on a "dreamlike" character, a wish-fulfilling and cathartic quality, it provides fantasy support

for venturing freely into the realm of unconscious thought processes.

Fluctuations in degree and quality of emotional tension characterize sessions of the therapy group. The emotional life of the therapy group itself can be likened to the variety of emotions that may be associated in a dream or dream series during which the same person experiences such sensations as anxiety and joy, speed and slowness, failure and success, isolation and social belongingness, power and weakness, and fleeing and pursuing. Klein-Lipshutz (1953) noted that patients will produce significant dream material more freely after having become part of a therapy group. It was also reported by this investigator that the latent content of the patient's dream seems to become more readily acceptable by the group.

### The Empathetic Method of Dream Interpretation

A method of dream interpretation recommended by many experienced therapists involves the assumption of a naïve and empathetic attitude. It is, therefore, not a miracle that inexperienced and untrained patients can do a good job with dreams, even without the help of the professional therapist. In this connection, Gutheil's recent recommendation for professional psychoanalytic dream interpreters is to the point:

. . . In order to comprehend the deeper meaning of a dream, the analyst must first expose himself passively to its manifest content. *He must detach himself spiritually from all he has learned* about symbolism and concentrate exclusively upon the reproduced drama of the dream. If he keeps his mind flexible, he will soon obtain a suitable point of "entry" into the hidden context of the dream.<sup>1</sup>

From the moment an individual becomes a member of a therapy group, his dream content changes in the direction of including more human figures, more interpersonal interactions. These figures usually provide a background or audience against which the actions of the dreamer take place and toward whom the audience reacts in approving or disapproving manners. Approval

<sup>1</sup> From *The handbook of dream analysis* by Emil A. Gutheil. Copyright 1951, Liveright Publishing Corporation, New York. P. 585.



or disapproval of the therapy group is frequently the manifest content of the patients' dreams. This may well be a cue to the nature of the therapeutic process which is specific to group therapy: the patient tends to transfer to the group societal authority over correct, i.e., "adjusted" behavior.

The number of ways to analyze dreams in a group setting is great. Research in the field is at the beginning only. No agreement either as to functional therapeutic significance or clinical management of dream interpretation in therapy groups has been reached. A more detailed study of a therapy group's dream reporting and interpretive work is an economical way of gaining a feeling for the dynamics of therapy groups. An annotated selection from our large collection of protocols on dream reports and dream associations in the group is given below. As will be noted in these protocols, the therapist in our regime makes contributions, in terms of dream interpretations, rather rarely. This makes it possible for the professional reader to apply his own interpretations and thus gain his own perspective on the projective communication processes occurring in therapy groups.

### **Dream Protocols**

The first dream protocol to be presented was reported by a member of Group II, who overtly rejected the group's influence. Her dream shows the strong emotional effects of the group on her, which are repressed in consciousness but are expressed in this dream. We are also presenting two dreams of the same patient in Group II (V-F) to illustrate the longitudinal intensification of the deep effects of participating in group therapy. In the first dream, following the twelfth session, there is already strong emotional effect, yet it is mixed with mother, father, and husband figures. In the second dream, after the forty-ninth meeting, this particular patient's reaction to the group's pressure on her to change her way of thinking is clearly demonstrated.

The first dream is one of the most elaborate and extensive dreams about group life reported to date. A clinical summary of the background of patient V-F reveals that the patient was in the process of divorcing her husband on the ground of his infi-

delity at the time of the first dream. She originally came from insecure financial circumstances, and had been advised by her lawyers to secure relatively large sums of money. She has conflicts about this. Some of the males in the group have accused her of being too hard on the separated husband. But the really acute conflict is not the financial one, but the fact that the separation has induced a tendency to regress to mother dependency. (Cf. dream content toward the end of the first dream.) She was able to carry out her divorce plans by reason of the very recent migration of her parents from the Midwest to southern California.

The history of the relationship between the patient and her mother and father is Oedipal in the sense that the patient's father had indicated during the patient's childhood a criticism of the mother as being neglectful of him. The mother showed her independence of the father by holding a position, by taking long trips away from him, and by neglecting to run the house on the meticulous standard desired by the husband. The patient felt that the mother neglected not only the father, but also her in her childhood. Because of this history, both the patient and the mother exhibit a readiness to undo the neglect and belatedly "find each other."

The patient sensed this as a danger of regression soon after entering group therapy. In her group, as in all therapy groups, the problem of young adults weaning themselves belatedly from involvement in parental influences, either protective or rejective, is one of the most common themes of verbal group interaction. The acute nature of her reality problem (divorce) had concerned the group, as well as the alterations in the relationship to her mother and father which came as a consequence of the separation. The separation from the husband, whose open and relatively flagrant infidelities she could no longer tolerate (in view of her own lack of sexual gratification from him) was very traumatic because of a fixated and unconscious rivalry with the mother, demonstrating to both mother and father her own superior domestic qualities.

With respect to the mother conflict, the group recently had several discussions in which the men particularly remembered

interferences on the part of *their* mothers with the development of deeper and freer relationships to the opposite sex during their late adolescence and young adulthood. These discussions were occasioned by an acute situation that had arisen in the relationship between one unmarried male member and his mother who was exerting all her influence and ingenuity to keep the adult son tied to her and to break any romantic attachment to a possible sweetheart. Dr. X is a colleague of the therapist and the patient had been introduced to him. This first dream was reported after the patient had had about twenty hours of individual consultation and only twelve group therapy meetings.

#### PROTOCOL No. 9: DREAM REPORTING

I [Patient V-F] was sitting in the basement playroom of the home of one of your colleagues, Dr. Bach. You and someone I thought was your wife had brought me along as you stopped in for a beer. As we were talking and enjoying ourselves (there were about six in the group), several more people dropped in. A gay convivial party began to develop. I was having a wonderful time. You, Dr. Bach, were sitting along a wall with a group of people around you. You were being both clinical and very humorous, as everyone was laughing. I was dancing and having quite a lark, but I wanted to come over and get you, Dr. Bach, to dance with me.

Somewhere during the period my parents came to the party. They were shy at first because here was "the great Bach" I had talked so much about. After a while they intermingled and began to enjoy themselves. Mother seemed to be watching me out of the corner of her eye. Dad, after quaffing a good deal of beer, became extremely jovial and gay. Then Dad came up—rather tipsy—and said he thought he had better get outside, he felt ill. At that Mother rushed him out. I went out with them to the sidewalk. Suddenly Dad seemed completely sober and well. Without further comment or ado they left, and I returned to the party.

When I came in, you, Dr. Bach, were sitting with a large group laughing and talking. I suddenly noticed K [the separated husband] sitting nearby. I was annoyed with him for not joining in, as I was annoyed with him so frequently in the past. K's upper torso was bare. I drew him to the center of the floor to dance. He came as in a dream, no response, no animation. I was irritated. I snapped him on the chest with my finger in a rather sadistic manner



calculated to sting him and awaken him. He reacted with anger and a small welt rose. I was chagrined at my action. I was on the defensive and said, "Well, why don't you participate?" Just then Dr. X, your colleague, came up and said, "I'll participate, snap me," and he offered his bare torso. I was embarrassed, but I snapped him gently and then my own torso was bare and I rubbed him lightly with my breasts to show him I really didn't mean anything by the snap. Then I was completely dressed again. No one noticed anything unusual. K then seemed to disappear.

The next scene was leaving the party. There were two carloads of people. We were all hilarious. We were driving at a breakneck speed down a divided highway toward the ocean. I was fearful of the speed and the fact that we had had too much beer. I mentioned this to Dr. X, the driver. He laughed. The highway was brightly lit by the new fluorescent lights. There was a great deal of traffic. Suddenly we came to a *drawbridge that was raising right before our car*. I screamed at Dr. X, who didn't seem to see it. He jammed on the brakes but not before we went partially up the rising bridge. We rolled slowly back down with no damage. Suddenly a bunch of officers came by and a klaxon horn sounded. Someone in the car said, "Oh nuts, it's a Black Tom!" A Black Tom turned out to be a bombing drill for civilians on the bridge.

We were all nervous and frightened. Suddenly, from one of the other barges where people were being covered over with wood, *I saw my mother*. She rose up and started to scream that she couldn't stand being covered up like that. She was hysterical and started to wander away over some catwalks. I was fearful she would fall in the water and be drowned. I called out to her to come to me. She didn't hear me and teetered about in a daze. I screamed, "Somebody help her, please! Bring her to me, I'll take care of her!" I couldn't get to her and I was frantic. I was also embarrassed at my shouting, and was afraid that you, Dr. Bach, would attribute it to a mother complex.

Finally, mother was led to me. She was sobbing and in trauma. I wrapped her in canvas and let her lie next to me. Then at a command given there were two loud explosions under us. The barges rocked violently. From somewhere came the cheering of a crowd. Everything had been a success. At that I awoke sharply. I was not alarmed or upset—not even relieved—I simply was wide awake.

There are, of course, many things that can be said about this dream, but from the standpoint of a clarification of group therapy



processes, three important facets of the dream can be pointed up.

First, group reactions penetrate on a *deep* level; they seem to reinforce the person's capacity and wish for growth toward an independent existence. In the dream, while the mother complex is by no means solved, the need for its solution is definitely indicated and clarified. In the whole dream the patient talks to herself about the need for such a solution and when the solution comes, although it is a neurotic one symbolized by an explosion, the crowd cheers, the group approves.

Secondly, this dream is an example of the *communication function* of dreams. Here the patient communicates her feelings about the therapist. The dream indicates a deep transference to the therapist, as well as an association of the therapist as belonging to (a) the crowd or group and (b) the wife. One might say that the therapist appears in the dream in four forms: in his own person, in the person of the "colleague," Dr. X, in the person of the father, as well as in the person of K, the former husband. Already there are signs in this dream, following only twelve group meetings, of a forthcoming difficulty of adjustment to sharing the therapist with the group. Note in the dream the rather wild, dangerous car ride driven by Dr. X, while the therapist, in the back seat (!), is involved with others.

Thirdly, patients can become very involved with the group therapist. This patient is making strong attempts to lure the therapist away from the others. The group interpreted this dream precisely in these terms. This patient never adjusted to sharing the therapist. She belongs in our file of premature drop-outs. She refused, however, to accept these interpretations of the group at this time and maintained an "adequate front." Eventually, however, the reality pressure of the group, which was sincerely appreciative of her difficulties but at the same time did not accept her defenses, made it impossible for her to keep her attention away from the problem at hand.

The next two dreams were reported by H-F, a thirty-eight-year-old, unmarried patient, who previous to psychotherapy was under constant medical attention for twenty years in an unsuccessful attempt to cure colitis, a condition which recent psychological research has shown to be characterized by a background

of psychopathogenic conflicts (Seward *et al.*, 1951). These dreams are reproduced in longitudinal sequence to illustrate a therapeutic process of unique significance in group therapy: the overcoming of "resistances" resulting from "transference neurosis" through the "transfer of transference" from the therapist to other members of the group.

Also of interest, but not unique to group therapy, is the observation that dreaming permits reactivation of and regression to earlier trauma and fixations. Such dream regressions are of essential significance to the psychological rehabilitation of severely neurotic patients with serious psychopathological conditions in early childhood. One of the many very traumatic conditions in the early history of this particular patient was the continuous exposure to primal scenes. From her earliest recollection at the age of three-and-one-half years to young adolescence this patient was a frequent witness of sexual intercourse between her parents. In this patient, relief of symptoms and improvement in feelings concerning the self as well as her general outlook on the world occurred in spurts, which were always triggered by a concentrated rush of dreams. Telling these dreams helped the patient gradually to relieve her amnesia concerning childhood, and also permitted her, with the group's very sincere assistance, to accept her present libidinal and hostility problems. In studying and rehabilitating cases like this, one can easily see why Freud was so impressed with the remote causation of neuroses. In our practice, however, such "pure" cases have become rare, while the incidences of character disorders of young adults, reared in child-oriented families and who deviated considerably from the primal hoard model, have increased. Fenichel (1945) has observed the same thing.

The following brief dream is a specifically good example of the high intensity of "transference" reactions to the therapist which can occur in group therapy, for contrary to general belief, transference to the therapist can be extremely intensive in such a setting. Intensive transferences may be stimulated by the fact that in the group the unconscious fantasy of owning the therapist's love exclusively is so obviously challenged by the reality of his general acceptance and friendliness to all members. In this

connection, the dream of another patient, in which the therapist was an irresponsible gang leader, showed one form of neurotic adjustment to the inability to share the therapist. He is not sharable as long as he identifies himself with a bunch of deviants. He is owned by the group and since he cannot be had, he is no good.

The following dream by H-F from Group I was reported after a group session during which this patient felt completely rejected by the therapist—a repeated transference experience of this particular hysteric patient. The sexual significance of the symbolism need hardly be pointed out.

#### PROTOCOL No. 10: H-F's FIRST DREAM

I [Patient H-F] dreamed that the therapist and I were dividing money which we earned jointly. I was berating him for not giving me a fair division, screaming all the time that I was sick and tired of taking the short end of every deal I ever entered into, and this was one time that I refused to be cheated. He asked me what I considered a "fair" deal, to which I replied: 6:9.

Two weeks later the same patient continued the theme in another dream, following a group session during which she again re-experienced her "father's" rejection. The second dream of the same patient shows how she has transferred her feelings toward the therapist to the group as a whole, which enabled her henceforth to overcome her transference neurosis and obtain some benefit from her relationship with the therapist. She was able to tell this dream to the group, who responded as shown by the following protocol.

#### PROTOCOL No. 11: H-F's SECOND DREAM

H-F: I had a dream in which I was completely rejected by the group. I dreamed that everyone had left after dinner at the post-session, except B-M, F-F and myself. I asked where G-M was. I had to get back to my car. B-M told me that everybody had left. So I asked him, "How can you all leave me when you knew that I had to get back to my car?" B-M said, "That is too bad. Now you have to find your own way back to your car." F-F sat by and latched on to me. I asked B-M to take me back

to the car. He said, "No, I do not go that way." "What am I going to do?" "I don't know. I am going home." And I was left sitting there with F-F. [Association: God forbid, that I be left with the F-F's in this world!]

Therapist: Do you feel that in the dream you are telling yourself that there is the danger you will be left in the world like F-F?

H-F: Of course. F-F stands for complete aloneness and despondency. Help me with the dream.

Th.: What part is not clear to you?

H-F: It's only too clear. I would like you to contradict the meaning I see in it—that I be left alone like F-F is.

Th.: In the group, or in life also?

H-F: It's the same thing, is it not?

Th.: What about your dependency for help?

H-F: I am not getting any help—from *you*. I have felt this for weeks. In the dream you are B-M.

Th.: What are you telling yourself in this dream?

H-F: That I have to find my own way. I have to find my way back or else I am doomed to sit inanimately, lifeless, like F-F does, forever.

Th.: I feel this to be a step toward weaning yourself from dependency.

H-F: Parts of it also mean that I cannot find my road back to security just through a man. [Association: my lover. Continued discussion of feeling rejected by present lover who, patient feels, could be any man—could be B-M, could be the therapist.]

The next dream related occurred after the patient had shifted her original transference from the therapist to a popular male member of her Group I. On the overt behavior level there were no sexually significant episodes in the relationship between the dreamer and the object of the transference, G-M. As a matter of fact, this patient, G-M, is characteristically emotionally reserved.

#### PROTOCOL NO. 12: H-F'S THIRD DREAM

I dreamed I was lying in bed in a room which contained two other beds. G-M was in one bed and his mother was lying in the bed to my left. The mother fell asleep, and when she began snoring I went into G-M's bed. We were indulging in sexual aberrations when the mother awakened and discovered us in horror. She angrily fell upon me and beat me terribly. I was cowering in fear



and was beaten into insensibility, all the time screaming in terror, but there was no protection or remonstrance from G-M. In my insensibility I was moaning in agony and felt my throat strangling with inarticulate cries of pain, while struggling to regain consciousness.

When I finally came to, she put me in a room by myself. There were two beds in the room. One was piled high with cushions and she ordered me to get on that bed. I was so badly beaten that it was sheer agony to climb onto the bed. The room was terribly cold.

After a while I was able to crawl out and I went back to their room on crutches. She apparently was again asleep. G-M sat up in his bed, delighted to see me. On my crutches I did a dance for him to a very gay Viennese tune (Narcissus). I wrapped a very bright drape around me to hide the crutches. He applauded so vigorously that the mother got out of bed. He too. I started to taunt her that no amount of beating could kill my desire to dance and asked her to close her eyes and imagine that she was young again and at Maxine's, whereupon I heard the gay Viennese tune again and started to perform the same dance for her. This time I did it without the crutches, all the time feeling wondrously gay and mocking.

The group was much interested in this dream. They frankly noticed that the patient is unconsciously pleading with G-M for love and protection, the kind that she could not get from the therapist. They felt two aspects to be representative of progress: (1) that she did remember and tell this kind of dream to the group, and (2) that she for the first time revealed some unconscious hostility toward, as well as independence from, the mother figure. A minority interpretation stressed that G-M was symbolic of all men in their "uselessness" when one needs them. This minority felt reinforced in their own perceptions of H-F as a "masculine protest woman," who uses feminine methods only to prove the male's weakness.

### The Therapist's Role in the Group's Dream Work

Of particular professional interest is the role the therapist plays in reacting to these dreams. The author feels that this, as any other aspect of group therapy, depends upon whatever theo-

retical approach a therapist may take. Why should this or that particular therapist's method of participation in the dream theme be in any way a standard? Every group therapist participates in very different ways. There are many degrees and kinds of possibilities from Moreno's method of very directly activating dreams through psychodrama (Moreno, 1952) to Hobb's (1951) refraining from any thought of reinforcing any particular form of participation.

This writer prefers to participate with the group in its basic emotion of wonderment of what a dream may mean. The therapist "models" a curiosity as to "what did I tell myself in this dream?" That is, he follows that aspect of Gutheil's (1951) suggestions which recommend the assumption of a "naïve" and empathetic attitude, and free-associative participation, if he participates at all. If the group therapist yields to the always present dependence wishes of the group to let *him* interpret difficult dream symbols, he then establishes himself as superior. While his superiority in this department is generally assumed anyway, the demonstration of it, in psychotherapy experience, evokes more complications from a group-dynamic standpoint than the possible gains may be worth to the individual whose dream is more sharply interpreted.

Technically perfect interpretation on the part of the therapist would weaken the group-centeredness and reinforce the leader-centeredness of the group. In general practice high-powered, expert interpretations, simplifications, and condensations of dreams are consequently withheld. The personal, "naïve" type of associative activity in response to dreams occur more or less spontaneously. "Knotty dreams" are just that: they are unsolvable by the group. If they are truly significant, the theme will recur again later, perhaps in clearer form. These occasions for experiencing to a limited degree an understanding of psychical phenomena result in a healthy respect on the part of everyone for the intricacies of the unconscious.

Any demonstration of authority enhances the neurotic hope of individuals to find a pillar to lean on. This, everyone knows, is undesirable for therapeutic progress. One of the undesirable consequences of evoking dependency is the counterphobic reac-

tion to it which frequently expresses itself in terms of attempts at outdoing the therapist and rivaling with his "brilliant" dream interpretations. This reinforces intellectualism, which, as is well known in clinical experience, is the most effective type of resistance, the enemy par excellence of psychotherapeutic efficiency (Kupper, 1950). It may even have the unconscious effect on the patients of producing very complicated dreams, dreams that are challenging to the skill and art of the official dream interpreter. Interpreting dreams regularly may create an atmosphere entirely unintended. Unconsciously the group culture is limited and restricted to a leader-follower relationship in which the leader constantly demonstrates his leadership by some sort of superiority in knowing the unconscious. Parading a superior knowledge of the unconscious seems only to reinforce the already rather high anxiety in a human being who is undergoing the fishbowl process of psychotherapy.

In one respect, however, the therapist gives all he can in a dream interpretation, and that is in the case of his own dreams. Here he feels that it helps the group for him to demonstrate occasionally how much he himself takes his own unconscious cues seriously, how he himself struggles with their meanings. In the one hundred sample sessions of Group I, the author gave a dream of his own on only two occasions, working on it fully each time, and in Group II, which is the more intensive group, he gave, during the one hundred sample meetings, eight dreams of his own, followed by full associations to them. The group members sense the therapist's intention of modeling that he does value for himself the cues received through an understanding of his own dream life.

### Dreams Viewed as Communications

Dreams have communicative significance beyond simple projections or conversations with the self. It is most unreasonable to assume that the dream thought could be without reference to communication to others. It would be very difficult to explain certain dreams one has about associates without reference to the state of communication between others and oneself in reality.

The communicative functions of a dream or certainly of a dream report, must be taken into consideration. When a patient dreams that the group doesn't help him, he dreams with his unconscious knowing full well, even if his ego doesn't, that he will tell this dream to the group just as in individual psychoanalysis the dreamer's unconscious is, even though his ego isn't, fully aware that he will tell the dream to his analyst.

One wonders how many manifest dream contents, which owe their latent significance to the quality of interpersonal affairs between analyst and analysand, have been misinterpreted in terms of rigid symbolism. Would it not be a scientific oversight to ignore the transference dynamics of communication as an important determiner of dream content? In view of the intensive interdependence of person with person, as especially and most intensively exemplified by the transference phenomenon in psychotherapy between therapist and patient, and between patients and patients in groups, it is unreasonable to assign to dreams an intradermal or "projective" significance *only*.

In order to emphasize the communicative or interpersonal significance of dreams, we would expand Erich Fromm's (1951) statement that a dream is a "thought activity during sleep," to include the fact that the dream represents not only a communication of the self with the self, a sort of soliloquy, but that it always includes a communication to the world outside the ego. To whom does the patient having a nightmare cry out literally and in the dream? Whom does the somnambulist look for? Himself? Whom does the panic-stricken dreamer clutch in the bedpost? There is no isolation of the psyche—neither in the waking state nor in sleep. In another publication (Bach, 1952a) the writer discussed the possibility that such traditional, intradermal, ego-structural aspects of behavior, as memory, also serve in here-and-now communications. Patients have demonstrated, in their memory reports of childhood, that their unconscious is very interested in making sure that their present biosocial contacts between themselves and other significant people are maintained intact and are improved.

In group therapy practice it is necessary to modify the Freudian dream interpretation technique, which was designed for in-



dividual analysis. Emphasis on a technically complete and "correct" understanding of dreams fosters a strong dependency on the group therapist, which results in an undesirable regression. In speaking of concepts of symbolism, Fromm (1951) thought that Freud believed "that the main function of the symbol is to disguise and distort the underlying wish. Symbolic language is conceived (by Freud) as a 'secret code,' dream interpretation as the work of deciphering it." Untangling the process of distortion and disguise, untangling the so-called dream work requires, according to the Freudian orientation, the kind of specialization and experience exhibited by experienced analysts and psychotherapists. This cannot, of course, be expected from most patients in therapy groups. Freud's very definite emphasis upon the fact that dreams are very complicated and that their "true meaning" is disguised (by condensation, opposition, and by other camouflages) may be, as Fromm implies, the result of Freud's own blind spots about his own dreams. After all, Freud analyzed his own dreams without help. In any case, cohesive groups are quite capable of extracting much meaning from dreams. Because every member's associations are naïve, neither trained nor intellectual, they are similar to interpretations given under hypnosis.

Fromm has noticed that in dreams excellent judgments and perceptions frequently occur concerning *other* people. He writes

. . . in the state of sleep we are capable of intensive insight which permits us to interpret a dream by dreaming its interpretation. . . . People put under hypnosis and asked to interpret various dreams give without hesitation a meaningful interpretation of the symbolic language employed by dreams. . . . We all possess the gift to understand symbolic language but . . . this knowledge becomes operative only in the state of dissociation brought about by hypnosis.<sup>2</sup>

The optimal group therapy atmosphere makes possible this "state of dissociation" which is conducive to furnishing basic material for the interpretation of symbolic language. Total group participation gives "fantasy support" (Bach, 1945) for venturing freely

<sup>2</sup> From *The forgotten language*, copyright 1951 by Erich Fromm, and reprinted by permission of Rinehart & Company, Inc., New York. Publishers. P. 128.

into dreamy-like associations. The incisive perceptions of other group members which occur in dreams of patients add to the fund of material for the "*theragnostic*" work phase of the group (cf. Chapter 12).

In summary, the reporting of and associating to dreams is one of the most effective communication vehicles for intensive group psychotherapy. Because dreaming is not a deliberate activity, the patient's ego does not feel as "responsible" for his dream-thoughts as it does for his social acting-out patterns over which actually he also has no control, but which he believes he *should* be able to control. It is this relative "safety" of the ego from the dream that permits patients to communicate through their dreams, and through their dream-associations clinically basic and "deep" material to themselves and to other patients about their selves and about their perceptions of others.

### Projective Drawings

Projective drawing is a warm-up technique to stimulate discussions on an emotional level. Both the therapeutic and diagnostic significance of drawings has been recognized by all students of psychological and communicative processes (Goodenough, 1950). In therapy, drawings are used as vehicles of interpersonal communication. Projective drawings are elicited, utilized, and interpreted from the standpoint of interpersonal communications in the group. Why are quick drawings effective aids in the communication of emotionally significant materials? Many emotionally disturbed persons, more so than relatively less disturbed persons, have strong inhibitions against verbal communications of inner experiences. To circumvent some of these inhibitions, Jung (1935) widened the medium of communication between himself and his patients by having them express themselves through the pictorial medium. Jung argued that certain factors of the subconscious were best represented by figures and nonverbal symbolisms. Jung's germinal ideas have stimulated various contributions toward developing a so-called art psychotherapy.

Many group therapists encourage their patients to use drawings as a form of communication. For example, Baruch and Miller have given a number of suggestive papers on their understanding of how drawings by adult patients (1951) and by allergic children (1949) undergoing psychotherapy contributed to the efficiency of the psychological treatment. The use of projective drawings has become an almost standard adjuvant in group therapy.

Our sample Groups I and II used projective drawings (Theme 8) eighteen and ten times, respectively, during one hundred meetings. In these groups every patient had a tablet of drawing paper on file at the meeting place of the group. Three dozen crayons of different colors were available. A time limit of about five to ten minutes was usually set by the group for "drawing anything you like," then each of the participating patients held up the completed drawings. In a "going around" fashion, everyone speculated about the drawing. The artist, in turn, might acknowledge that some of the group's speculations "hit home." This "analysis" of drawings was carried on rapidly. It is remarkable how a few minutes of freedom from the usual verbal and logical channel of communication brings up unconscious forces through the pictorial medium. Clinical experience with drawings impresses one with the inhibiting, repressing nature of ordinary verbal communication. For example, intelligent, adult patients usually feel uncomfortable talking about water, clouds, trees and the moon, yet in their drawings these same people will invariably express their unconscious interest in these symbols.

While on the verbal level, patients repress or fail for some other reason to give a complete picture of the self, they very frequently draw self-portraits. Many students of the psychological and projective significance of drawings would agree with Kinget's (1952) statement that self portraits "are a highly reliable indicator of the subject's feelings and attitudes, as the portrayal of the inner self, the concept of the self portrait."

Another indication that repressed material is stimulated by drawings is the fact that patients are usually at a loss to describe

verbally their feelings about the therapy group. Such verbal descriptions, when they are managed at all, are very "thin," and the patient himself senses that the verbal symbols do not begin to express the rich quality of underlying feelings, which apparently are not reportable however hard one tries. Yet when patients, who are technically untrained, use their crayons for a few minutes, they can and do give rather interesting expressions of their views of the therapy group, as our illustrations on pages 145-148 show clearly. This peculiar quality of pictorial communication to *externalize that which is not fully expressable verbally* makes drawing, in the opinion of this writer, fully as useful as dream reporting in psychotherapy. Does not the value of gaining insight from dreams stem, in part at least, from the pictorial, nonverbal dimension of the dream?

### Resistance to Drawings

The process of drawing in groups is not particularly popular with patients. They will choose it, on the whole, less often than any of the other warm-up techniques. This resistance of the group to drawing is a protection against getting into unconscious material that cannot be handled on a verbal level. In dream reporting, for example, this problem is solved by forgetting the dream, but one cannot forget a drawing which is submitted for detailed analysis by the group.

Another less dynamic factor accounting for this resistance is the neurotic's feeling of inadequacy and failure about any of his productions. This is given as an explanation by many patients in discussions of the group's resistance to drawing. Other patients mention that drawing has a regressive influence, that it immediately puts them back to their school days, where they were expected to perform and were graded on their performance. In response to this rather valid and genuine resistance, some of the author's groups have developed a "Round Robin" type of drawing technique.

When a group decides on a Round Robin drawing warm-up, they limit each patient to one minute, during which he can "start something" on his drawing tablet. Then one member signals



to switch and each member passes his tablet to his neighbor. This is repeated as many times as there are participants, until the tablet gets back to the initial owner. This results in some six to nine Round Robin drawings by the group. In the ensuing discussions, two focal points emerge: First, there is some superficial interest in the rather remarkable fact that many of these Round Robin drawings emerge with a coordinated design which no one individual intended or foresaw. This is of interest to the social psychologist, naturally, and suggests a technique of research into group coordinative processes of communication. Secondly, there is a good opportunity to see what type of contribution each individual will make to each of the Round Robin drawings.

The drawings are all held up together and each member takes his turn in describing what he contributed to each group drawing. This often but by no means invariably results in the emergence of some insight on the part of the majority of the group, as well as of the patient involved, concerning characteristic externalizations of unconscious motivations.

### Insight Mediated by Repetitive Drawings

Some patients' hysterical defense systems are shown, for example, by the way they try to beautify every drawing with colorful decorations. Male patients, with strong castration problems, invariably add actual or symbolized male and female genitalia. More defensive patients always add moons, suns, trees and water. Many women patients add houses without chimneys, but perhaps with a cloud over the house. Some patients have to underline and frame everything. Others *must* put people into the picture. Still others do not have a feeling of configuration until they put in eyes. Some patients show their lack of identification with the group, their position as isolates, by their contribution to the Round Robin of highly esoteric, very irrelevant symbols, which make it difficult to achieve a design for those patients in the group who always look for closure in the drawings. Some patients externalize their submissive, dependent status in the group by giving only extensions and elaborations of

that which has already been begun by their neighbors, or by repeating the contributions of others, perhaps with a different colored crayon. Patients with strong negative transferences to the group as a whole will make "contributions" that are hardly disguised destructions, spoiling the group's pictorial production. Patients with extreme negative transferences to the therapist may use this opportunity to put him in some unflattering caricature, as a devil or a mean giant, or by using the black and red crayons very generously on his figure.

Let us take the case of a patient who has participated during the last one hundred meetings of Group I in eighteen drawing sessions, and let us assume that all of these eighteen sessions were Round Robin sessions, rather than straight drawings. Let us further assume that the average attendance was seven and the therapist made the eighth participant. Thus, during this period, patient X made eighteen times eight, or one hundred and forty-four, quick drawing contributions. These invariably fall into certain patterns, subject to recognition and discussion, not only by the therapist and the patient, but by the entire membership of the group. As a rule all patients are quite interested in this analysis, if for no other reason than the fact that some of the members' contributions spoiled or enhanced or brought out just what the initiator of the drawing supposedly had in mind. Patients are naturally and genuinely interested in seeing who has done what to his particular tablet.

However, groups do not stick to such a neat routine. Usually, there is a combination of Round Robin and individual drawings, and, as was mentioned before, there is always a tendency to get away from the pictorial material and back to discussion. There is no doubt in this observer's mind that the patients feel exposed by the drawing technique, even when the Round Robin is used. They are very happy to leave the drawings and continue on a purely verbal level. On several occasions, groups got caught in deep emotional discussions in connection with drawings and never got away from them during the entire two hours. Unfortunately, such sessions arouse too much anxiety and keep resistance against using drawing again alive for some time.

## Drawings Reflect Nature of Participation

Five different categories of drawings can be distinguished, each highlighting some characteristic of the participative experiences which patients have in intensive group psychotherapy.

**1. Self Portraits.** Figure 1 by Patient F-F of Group I was started by her and elaborated in Round Robin fashion by the group, i.e., the group added to and completed the drawing. The infantile character of this self portrait is evident upon inspection. The patient, F-F, is (when not too handicapped by feelings of failure) a very talented artist who started the drawing by a quick outline of the face of a very young child. The group continued



FIGURE 1. Self-portrait by Patient F-F, seen as the "baby" by the group.

the sketchy design. By elaborating on the original suggestion, the group communicated its general perception of this patient as the baby of the group. Here we have a combined self portrait and a portrait of a patient's role in the group. Both individual and group are aware of the role of a dependent, submissive "baby," who wants to be taken care of. Note in the left-hand corner of Figure 1 the glass of water, a spoon and pills. These represented one member's feeling about the patient's wish to have her psychotherapy "spoonfed, like medicine." Notice, too, the addition of balloons and/or lollypops on the side, giving further emphasis to the infantile impression. The discussion of this drawing brought to light the fact that the group was threatened by the presence of this overdependent member, whose demands for love and care no one could realistically satisfy.

2. **Wish Drawings.** Figure 2 belongs to a category which can frequently be seen in patient's drawings, the category of *wish fulfillment*. Patients' quick drawings frequently get to a central wish. This is in contrast to verbal discussions where the particular wish portrayed in the drawing is either not recognized



FIGURE 2. Intercourse-wish expressed in drawing by Patient K-F.



or is denied. Figure 2 represents the marital bed, drawn by Patient K-F. The wish for intercourse with her husband, with whom she has had no sexual relationships for over one and one-half years at the time of the drawing is clear. Up to this time this particular patient, a compulsive neurotic, has not admitted to herself or to the group that she would actually like to have the opportunity for love-making with her husband. The group in this case was impressed with the outspokenness of the drawing, as well as the acknowledgment by the patient of something which she previously had been very defensive about. The group was satisfied with the patient's insight and did not elaborate with further associations.

**3. Life Perspectives.** Figure 3, contributed by A-M, the paranoid role carrier of Group I, falls into a category of drawings which we may label *drawings of life style or life perspective*. The group was very shocked by this drawing and at first made very little comment, except to point out that there are no people in it and that it is typical of A-M's fear of people. The patient then revealed, after withholding for a while, that this was partly a representation of a dream, in which he felt himself locked in an empty room, and panic-stricken that he might die from an injection he had received from a doctor (castration). He wished in the dream that he was 800,000 miles away, using the car to make his getaway. In the case of this patient, the group sensed how little ego control was present. As a consequence many of them expressed that they felt sorry for him, that this was a very depressing dream. They all agreed, however, that it represented A-M's style of life—feeling alone, yet being afraid of people and of death, and having only one method of coping with it, that is, fleeing. One patient mentioned that the hypodermic needle represented A-M's experiences of anxiety and pain in the course of psychotherapy (!), to which another member added the reminder that A-M recently had taken a long "vacation" from the group. A rather serious group depression accompanied this discussion of Figure 3, indicating group sensitivity to uncovering too much unconscious material in a disturbed patient. The therapist refrained at this point from interpreting the possibility of homosexual anxiety in relation to the therapist

(doctor's dripping needle), illustrating the technical principle of *not* communicating all meanings of the symbols either in drawings or in dreams, but to let the group find and use what significance they can assimilate and apply.



FIGURE 3. A style-of-life drawing by Patient A-M, expressing a castration dream.

**4. Views of the Group.** The next four drawings show how different patients see the group differently. Figure 4 was contributed by M-F of Group II, a very artistically gifted patient. The group liked this drawing very much, although they thought it was typical that M-F thought of herself as the smallest fish at the lower center of the drawing. Some patients commented that she could have put herself even farther away from the group, but they were encouraged that she put herself swimming in the same direction as everyone else. Some attributed turbulence and considerable action to the water. Others saw normal movement and "progress." The group was not only pleased with the design and color, but they were actually surprised, for up

to this time the patient always maintained a very aloof attitude toward the group. She played the role of the silent and rejected one. But ever since she produced this picture, members of the group reminded themselves and this patient that perhaps she was more deeply identified with the group than her overt behavior showed up to that time. The use of six different colors also indicated flexibility and a zest for life to the group, which this patient was thenceforth never permitted to forget.

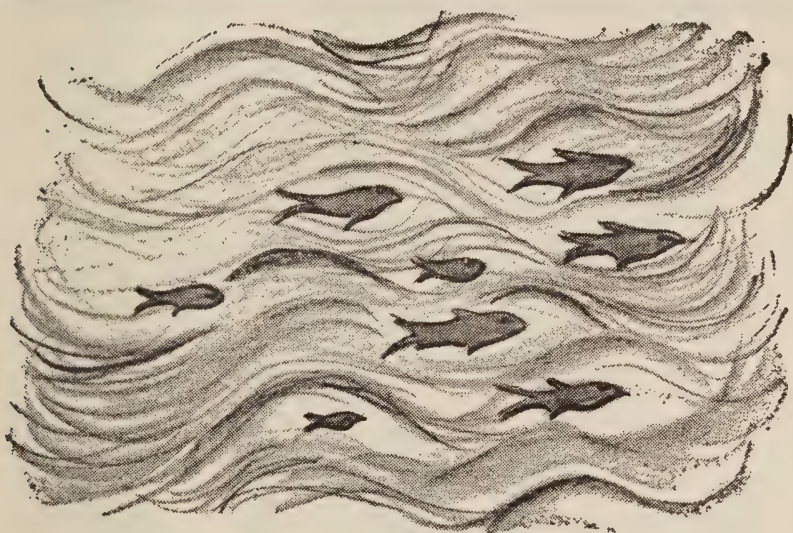


FIGURE 4. View of the group showing a strong feeling of belonging, contributed by Patient M-F.

In contrast to her drawing, the drawing of the group by T-M of Group II (Figure 5) shows a rather defensive, low level identification with the group. The figure represents the coffee table around which in reality the group members are seated and on which they put their cigarettes, knitting, handbags, and other personal belongings. This patient could not say anything, least of all say, "This is a drawing of the group." He called it "a drawing of the table." The group related his repression of people in the drawing to his repression of verbal reactions in the group. They squeezed out of it some hopeful signs in the use of several colors and in putting two cigarettes and the belongings of several



members into it. Two women patients brought out the possibility that the patient who drew the picture had a deeper interest than he admitted in the girl to whom the knitting bag belonged. This led to an admittance on the part of this very schizoid and withdrawn patient of a strong sexual interest in U-F. It was the first time, in over a year of group therapy, that this patient was able to communicate a rather deeply-sensed feeling to the group. This illustrates how the use of drawing facilitates not only insight into, but also communication of repressed emotions.

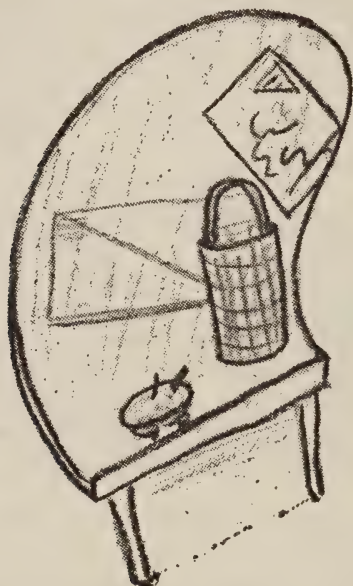


FIGURE 5. The group as seen by a schizoid patient (T-M), expressing repression of the wish for love objects.

Figure 6 is a drawing of Group I as seen by patient J-M, who himself is represented, according to the group's interpretation, by the little Kilroy "Peeping Tom" figure below the first skirt. From a study of this drawing the reader is immediately reminded that the constellation of Group I is a mixed sex group. This thirty-seven-year-old male patient, however, referred to the group for the psychological treatment of functional impotence, represents only females and only the lower half of their bodies. Since



this patient was quite new in the group, he attached "no significance" to this drawing, and the group demonstrated its remarkable capacity for tact in the case of a newcomer by not pressing any elaboration. They kept their associations on the superficial, but acceptable level of the Peeping Tom theme, where the patient is threatened primarily by the presence of women in the group. The new patient laughed it off with a certain sense of curiosity, saying, "You really think so, eh? Well, George would probably, too, huh? I guess anything is possible here."

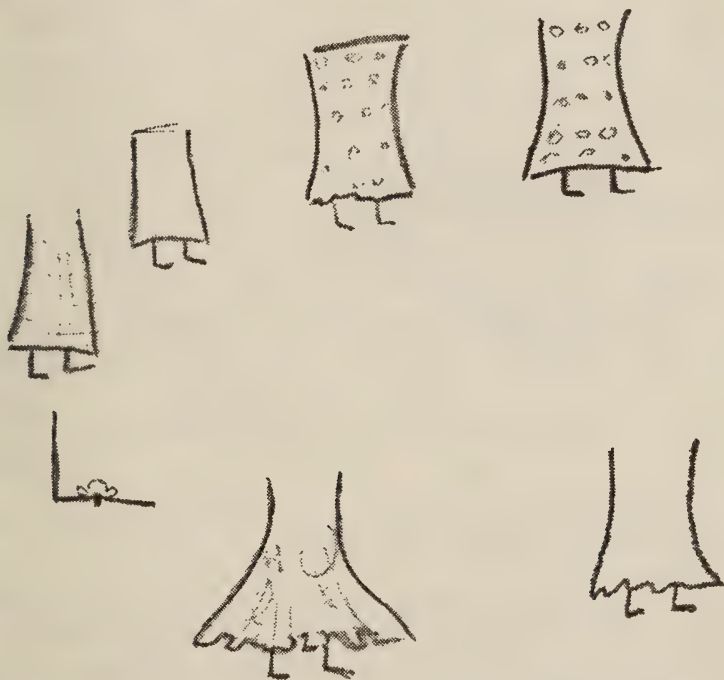


FIGURE 6. A mixed-sex therapy group as seen by a patient with unconscious hostility to women, contributed by Patient J-M.

Figure 7 is a Round Robin production by Group I. It was made the evening of a birthday party. The starting point of this picture was just the one bottle in the lower left-hand corner. The rest was an attempt to complete the drawing. This figure suggests the fact that the Round Robin technique is very similar

in process to the drawing completion technique (cf. Wartegg, 1939; Kinget, 1952). In discussing the completed drawing, the group felt that it represented how the majority of the group members felt about the group that evening. It was agreed that several in the group thought of the therapy group as a social party, a mood which was not only acute that night, but which had prevailed during many earlier meetings of this group. This



FIGURE 7. A round-robin view of the group expressing a desire to grow into a work group rather than a play group.

led to a rather heated discussion of how certain patients make it difficult for the group to grow out of a social play phase and into a clinical work atmosphere. Positive transference feelings were expressed toward the therapist, who was put into the drawing as the upper left-hand stereotyped male profile. This was recognized by the group as expressing their need for clinical leadership to get away from the social play phase of group life. It may be of interest to point out that the bottle, the hot French bread, and the beans were contributed by two oral regressives, while the enchiladas and the four females were contributed by a hysterical, exhibitionistic patient.

**5. Group Designs.** Figure 8 is a rather typical Round Robin production, inasmuch as group designs often turn out to be very symbolic or bizarre. Groups usually respond with curiosity to the discussion of symbols in Round Robin productions. They encourage each patient to examine his own individual contributions to the Round Robin series, which involves several drawings. We can perhaps gain a glimpse of the process when we notice that in Figure 9 some patients contributed horns or hardly disguised penes, while others contributed the sun, the moon and the tree.

The *mask* content of Figure 8 is a common type of final organization in Round Robin drawings. In mask drawings, eyes, noses, and holes are usually featured. As in the case of Figure 8, the bars in front of the eyes are also frequently present. Sensitivity to "having the head examined" is represented by the two holes in the forehead. In the group discussion it was pointed out that the starting point of this drawing consisted of three ogives with steps leading to them, supposedly representing a circular psychodrama stage and the approach to it. This beginning now surrounds the three central holes in the mask; the steps are still visible in the nose.

### Drawings Contribute to the Therapeutic Process

It is impossible to assess what contribution to the psychological rehabilitation and growth process any single group activity makes. The following processes seem to be reinforced by projective drawings. Pictorial language is more primitive, more economical. It externalizes unconscious material and thus makes it subject to insight. Drawings facilitate the communication of feelings about the self and about the group, as well as specific emotional states in the relationships between members, and between patients and the therapist. The Round Robin drawings permit analyses of any individual patient's characteristic contributions to the group activity, which frequently reflect his adjustment problems in the group and in the world. Participation in the creation of group drawings reinforces cohesiveness and belonging.





FIGURE 8. Group-produced designs showing symbols of defenses commonly represented by patients.



A drawing may be rather superficially discussed, yet the impact on the patient who made the drawing may be strong and elaborated after the meeting, so that, in retrospect, the patient may feel that a really "deep" analysis of his contribution was made. Thus, through drawing, each patient gains the full attention of the entire group to his projections. This encourages him, through identification with the group, to pursue the motivational significance of his drawings further.

## Chapter 10

### IMPROMPTU ROLE PLAYING

---

Role playing is a very popular activity of the therapy group. Out of one hundred meetings, our Group I used parts of eighty-four meetings for role playing, and Group II used role playing in ninety-two of the one hundred sample meetings. The form of role playing used by these particular groups is "impromptu role acting." There are many other forms of role-playing therapy procedures (cf. Lawlor, 1947), ranging from Moreno's original psychodrama (1923), to the author's "play drama" technique. The play drama is a miniature form of the psychodrama, which has been described in detail elsewhere (Bach, 1950*a*). Our present groups make no use either of Moreno's psychodrama or of the play drama. Our groups prefer the informal, impromptu form of role playing.

#### Impromptu Role Acting

"Impromptu role acting" is a label for the type of verbal communication in which the patient speaks "in dramatic dialogue," like an actor, except that no script is followed. The dialogue is invented as the "actor" goes along (Horwitz, 1944-45). Role acting refers to the spontaneous impromptu dramatization of a situation which the patient either has experienced in the past or is about to experience in the near future. Informal role acting may deal with dramatizations of very early memories or again it may deal with present interpersonal adjustment problems in or outside the therapy group. In the following brief protocol, a new patient (B-M) is informed by two older patients (C-M and D-F) about various warm-up or "icebreaker" techniques, among which is informal role acting. The patients

refer to what we have labeled "impromptu role acting" in various ways, such as a "show," or a "scene," or "psychodrama." The use of the label "psychodrama" by patients is technically incorrect, for the term properly belongs to the techniques originally developed by Moreno (1946), from which our informal, impromptu role-acting procedure is very definitely differentiated.

#### PROTOCOL No. 13: IMPROMPTU ROLE ACTING

B-M (new patient, addressing the whole group) : We had two "psychodrama" scenes here last time in which you did very well. How did you make up those scenes? How do you know what to say and how to act?

C-M : If one person shows some disturbed feeling about his mother or father or some other person, he more or less stages a show or scene. I could take the part of your father and try to hold a discussion and bring out some feelings of yours that you had for your father. You do have to stage some kind of scene yourself.

D-F : It tries to bring out how you would act in a similar situation in real life, simulating your emotions at the time. You try to take the role of your father in some way, making remarks that would arouse your emotions or bring ideas into your head, mostly around your emotions. I did one in which he wanted to meet a girl. I was the girl and we went through a process of what he would say to her and how I would react.

The material for the scenes are frequently taken from post-sessions and other social contact experiences which patients had with each other. Role taking allows a "replay" of actual member-member contacts before the total group. Another source of material is "previewing" an anticipated contact experience which a patient may dread and which he tries to rehearse, thus trying to master himself before getting into the real situation. Usually such role-acting scenes are rather brief and used primarily to stimulate discussion and free association.

#### Role Playing and the Therapeutic Process

The current interest of the psychotherapist in role playing lies in the therapeutic possibilities believed to be inherent in the

practice of patients taking roles. An appraisal of the therapeutic efficiency of role playing would involve a discussion of the whole question of the relationship of play to learning. Many systematic studies of the function of play have been made since the pioneer work of K. Bühler (1929). The psychoanalytic theory of play developed by Robert Waelder (1933) is of particular interest. It stresses the active externalization, through play, of passively experienced and/or suffered interpersonal events. If, through play, the patient can re-experience and master incompletely absorbed past traumata, as well as anticipated conflicts, his obvious interest in this type of group therapy activity is understandable. Through role-playing procedures the emotional functions of play can be clinically exploited. The technique permits the patient to combine playful acting out with a serious attitude of understanding his conflicts.

Clinical ways of utilizing various role-playing techniques for mediating serious and realistically valuable therapeutic processes are employed particularly with children. Moreno (1923), was the first to recognize the psychotherapeutic potentials of play activities for groups of adults. Play is removed from ego-depreciating censorship, for it occurs in the protected world of "make-believe." Thus, it is potentially of high therapeutic value, not only for children but also for emotionally disturbed adults. In chronically frustrated neurotic and psychotic patients, fantasy life is not only abnormal in intensity, but is also frequently socially offensive because of its erotic, hostile, and nonhumorous nature. Social difficulties arise from the fact that persons in conflict cannot continually repress or suppress these feelings, but must sooner or later communicate them in some way to others. The impromptu psychodrama, originally introduced by Moreno, is a vehicle through which the suppressed and conflict-ridden patient can learn to become more spontaneously expressive.

In comparative experiments conducted by the writer, in which Gene Barker (1948) served as observer and interaction analyst, a psychiatrically diagnosed normal student group and two groups of psychiatrically referred neurotic college students were each presented with the same initial play drama (Bach, 1950a). The



comparison between better and poorer adjusted group therapy members proved the neurotic's more intensive interest in, or need for, the freedom of expression in play. Barker found that the adjusted group lost interest, while for the emotionally disturbed groups interest was maintained or increased as the therapy progressed. Lack of interest in role-playing therapy by the well adjusted group was indicated by a significant drop in the number of positive group emotions, such as humor, while in the two neurotic groups there was no drop in the positive emotion of the group as the activity progressed over several weeks.

This result indicates the intensified need for dramatic fantasy release on the part of the emotionally disturbed person as compared to the less disturbed person, whose fantasy needs are sufficiently taken care of by culturally provided outlets, and who has the skill and the emotional flexibility to make spontaneous use of a number of release opportunities. Impromptu role-playing techniques attempt to help patients to bring their private fantasies within the realistic realm of group discussion.

### **Seven Therapeutic Functions of Impromptu Role Acting in Group Psychotherapy**

**1. Reactivation of Deep Historical Material.** Role-playing techniques frequently attach themselves to mnemonic material. Intensive sojourns into the past are most economically undertaken by role playing. Since role playing depends greatly on imagination, vaguely remembered past episodes with significant others can be elaborately "re-enacted."

**2. Extinction of Phobias.** A second rather unique advantage of the impromptu role-acting technique has to do with a process which experimental psychologists would term "experimental extinction" (Hull, 1943). Through role playing, exaggerated, fearful anticipations of role-behavior consequences are found to be unwarranted. Many of our patients harbor strong phobic reactions to the actual acting out of suppressed and repressed motivations and conflicts. Role playing permits quasi-real experimentation or rehearsals of suppressed behavior. Con-

sequences can be studied and discussed. With the help of role-playing therapy, a foundation is laid for the examination (in more advanced stages of therapeutic growth) of the reality of these phobias. When a patient is able to play out the very behavior which he has often felt incapable of performing in reality (e.g., aggression, affection, etc.), the phobic sufferer gains a new, less fearful perspective toward roles previously associated with anxiety.

**3. Substitution and Mastery.** A third advantage of role playing in group therapy derives from the same principles that make the elicitation of projective drawings, dreams, and, in fact, any fantasy response therapeutic: fantasy responses, as the author's research in children's doll play responses to frustration has shown (Bach, 1945), can reliably be considered as having various substitute or mastery functions for suppressed actual actions, real satisfactions, real dangers or threats, and the like. Our experimental verification of Waelder's (1933) psychoanalytic mastery theory of play gives the group-therapeutic technique of using dramatic play responses a theoretical foundation, quite independent of Moreno's or of any other author's specific psychodrama or role-playing theory. In our own studies of children's dramatic doll play fantasies we were continually impressed by the effectiveness of play behavior to permit—as do dreams—a condensed and safe living out of realistically unfulfilled or avoided conflict or need situations. Dolls and clay figures represented the child's ego's fantasy support analogous to the manifest content of dreams which covertly carries the real significance of the dream message.

Playing the role of a different person, someone not the self, rather than really living out the behavior for which the self is in fact responsible permits the ego to venture safely, for a brief period, into the unstructured world of inner emotional needs. In the projective role-playing fantasies of children, we can see that with the doll characters the child sets up a family situation in which he makes the family members and his own identification doll behave repeatedly in certain characteristic manners with respect to interpersonal relationships. Frequently, it is possible to give two meanings to these regularities of role play themes:

(a) the child makes the doll people behave in the way he would like to have the real people behave. (b) At other times the child expresses through these patterns his mastery-wish or his fears that the real people might behave as he makes the dolls behave. In the latter case, the child strongly hopes that they will not, but at the same time he prepares himself for this unconsciously feared eventuality (Bach, 1945).

In the same way our adult patients lose themselves in role playing activities. When in the proper role playing mood, they follow a conditioned response mechanism which reactivates many years of childhood role-playing practice with their peers. Many adult patients are incapable of communicating on a so-called realistic and logical discussion level, yet these same patients fall most naturally into role playing, and they become extremely effective communicators in this medium. When they play a role they can behave in the way they wish they could behave in real situations.

**4. Sharing and Reality Testing of Fantasy.** We have noted above the hypothesis that the ego obtains substitutions and mastery satisfactions from engaging in dramatic role playing. This process automatically entails, in the group therapy setting, communication to and sharing with others the fantasies which become externalized through role playing. Through this sharing, the therapy group members can arrive at insightful perceptions of the individual patients' personality problems, as they eventually reveal themselves through some repeated and characteristic feature of his role-playing participation. After group consensus concerning the significance of a patient's role-playing fantasies is established, the patient himself later may be able to share and accept the group's analytic work.

Cameron and Magaret (1951) have noticed that role playing makes possible public sharing of the private fantasies of the patient, e.g., fantasies of a husband mastering the threat of a dominating wife, fantasies of a rejected lover convincing the partner of undreamed of virtues and advantages of association, or the dream of the male to be able to relax his constant vigilance and mask of masculinity. The recognition, the sharing, and the communication of private fantasy are among the very important

steps in the therapeutic process. This therapeutic process invariably involves the discovery that some of the suppressed behavior tendencies are, in fact, capable of realistic expression and that many of them have the character of positive impulses and constructive tendencies toward mutuality and love, that they need not be feared as either sadistic or impractical.

Attempts at realistic tryouts of the tendencies discovered through role playing can then be attempted in more advanced stages of therapy, which the role-playing procedures may help to initiate. The patient can gain insight into his tendency to make the world of real people behave in a way congruous with his fantasy world. He has a chance to sense that much of his anger with people and many of his socially unwise and impulsive acts begin to make sense to him when recognized as part of a campaign to force reality into patterns of fantasy. Acting out fantasy strivings can then be comprehended as doomed to afford the patient nothing but frustration.

**5. Encouragement of Patient-to-Patient Communications on a Safe Level.** Impromptu role acting represents interpersonal communications too charged with anxiety to be carried through under conditions of realistic discussion. Playing, as Moreno has so validly emphasized, is a protective medium in which experimentation with problem solutions can spontaneously take place. For example, in expressing hostilities through role play, the fear of retaliation is considerably reduced. Through the symbolic device of "speaking for a figure" or role, individuals can fight with each other, without creating animosities or evoking rejection on a realistic level. They learn how anger with real, live people is often a function of the necessary discrepancy between the movement of people in the fantasy community and the movement of people in the real social field. This discrepancy is externalized through the method of role playing. The demonstrations that therapeutic role playing afford are invariably remarkably impressive to the patient. Such experience initiates an ever widening curiosity about how other people see the same situation differently from the self. As therapy progresses, tolerance for differences is expanded and tensions in interpersonal living are reduced.



Role-playing techniques break the anxiety of the relatively nonparticipating members for two reasons. If they do take a role, they usually have more direction and coaching than they can provide for themselves in realistic discussion participation. Also, if they do not take on a role, they can listen passively without feeling that this is out of order. Such behavior, considered as out of order in the regular discussion group, is deemed highly appropriate and cooperative in role-playing activities.

Role playing facilitates identification processes, for its very essence is behaving like someone else, and in the absence of the real thing, this distinguishes the process from copying or imitation, as Sears' studies (1951*b*) have clarified.

Role playing, being in the area of fantasy, shares with other fantasy responses the characteristic of condensation which Freud (1913) originally described in his book on dreams. Role playing facilitates presenting a situation with fewer words, in less time, and with greater clarity than can be achieved with the ordinary reporting which occurs in usual discussion methods.

**6. Reinforcement of Empathetic Perceptions.** In the process of having to improvise how another patient in the group, or how another person in the social environment of the patient would act, the patient is forced to assume an empathetic frame of reference. In order to play roles other than that of the self, patients have to put themselves into each other's places. From a therapeutic standpoint this is a desirable experience for the neurotic patient who is usually so preoccupied with his own private inner struggles and latent conflicts. By participating through play in the life conflicts of others, social perspective is broadened and reality outside the self becomes interesting. When a patient sees himself and/or someone close to him portrayed by another member of the therapy group, the feeling of being deeply understood by others emerges in a convincing way. This strengthens rapport between patients and helps set the stage for that degree of emotional involvement between patients in a therapy group which is one of the necessary conditions for effective treatment.

**7. Improvement of Social Skills.** Many group therapists who utilize role playing techniques stress the very direct gains

patients are supposed to derive from role playing. Such workers think of role playing as "experimentations" with different ways of approaching realistic situations. Lawlor (1947) has given an outline of "role therapy" which includes the education of patients in the nature of roles. In Lawlor's technique, patients are encouraged to discuss in detail their reactions to role taking, their liking or disliking of certain roles. The practicing of new roles to encourage the building up of a role repertoire is stressed by Lawlor, who also mentions that role playing is a useful adjunct to intensive psychoanalysis.

Harrow (1951), another therapist who uses the role playing approach, described the therapeutic effect of this procedure on schizophrenics. A realistic problem situation is acted out and the patients' modes of interaction are criticized by the other members, who make suggestions for playing the role differently. The scene is repeated until the patient can see various ways of handling the same situation. In our program role playing is *not* used for the specific purpose of improving social skill. As a matter of fact, our clinical experience with the use of role-playing techniques for this purpose has made us realize the limits of role playing therapy.

### **Treatment Complications and Limitations of Role-Playing Techniques**

Like any other special therapy technique, role playing in any form is no exception to the rule that overemphasis on any one special technique may introduce definite complications. Any technique, if overemphasized, may disrupt or limit the spontaneous evolution of a culture in the therapy group. For this reason the decision to apply or not to apply any adjuvant technique, such as role playing, is, in our regime, not left to the clinical judgment of the group therapist. The decision to use or not to use any specific technique is the concern of the entire group. The group decides when and when not to use such techniques. During discussions of group decisions concerning the use of role play the author has gained some information, summarized below, as to the limitations of this technique.

**1. Ego Threat.** The "fictitiousness" of dramatic role playing affords protection to the ego against premature and shocking insight into previously unattended conflicts. Patients with weak egos sense the close relationship between their projective role play and their inner tensions. When through the use of a seemingly safe, "playful" technique, patients are prematurely "lured" into externalization of threatening materials, the result may at times be traumatic. It may eventuate in the intensification, rather than in the circumvention of resistances. Consequently, therapists do not encourage the tendency of other members of the group to press each other for insight into the often rather obvious identification between role playing and inner conflict.

Pressure toward premature insight is reduced in our regime by the "sitting in" technique described in Chapter 17. All patients must be given the chance to arrive at insight into the projective significance of their modes of participation at their own rates. The safe identification of problems is accomplished only through repeated modeling demonstrations of less defensive group members. Instead of being prematurely directed by an impatient therapist into a psychodramatic reactivation of their personal conflicts, patients should be given the opportunity to get ready to follow the model of another, more advanced and thus less defensive patient.

**2. Anachronism.** Advanced patients, who have progressed to the point in which they are concerned with and curious about their interpersonal relationships in the group (e.g., their transference dynamics), are very resistive and tend to vote against the use of role-playing methods. Their verbalized reasoning against the technique usually takes the form that they have tried it already, that it has done all it can for them.

It seems that role playing techniques are best used as an initiating group therapy procedure, as an icebreaker, in the early phases of the group therapy life. It may become anachronistic and obsolete when the group has developed to an advanced stage of therapy. Advanced patients object to the, to them, obvious unreality of role playing. They sense that the play roles are not only "childish," but that in a way it is a crutch which by its very presence reminds them of a projected implication of their inabil-

ity to relate themselves more realistically to the here-and-now of their group adjustment.

Groups desiring continually to use role play at the expense of more realistic discussion express in this way a wish for some defense, for escape from facing the interpersonal situations in the here-and-now of the group life. This is not an ironclad warning, however, because occasionally very advanced patients return to role play for quick scenes in almost every session.

**3. Anxiety Evocation.** Any role-playing procedure puts the patient "on the spot." The evocation of "performance anxiety" seems to serve no useful therapeutic purpose. As a matter of fact, to reduce such anxiety the patients may produce in the play drama an exhibitionistically modified performance which does not afford any really therapeutic experiences, save that of reducing the anxiety initially instigated by the introduction of the play drama activity itself.

**4. Individual and Cultural Differences.** Some individual patients are utterly incapable of participating in role playing, even under ideal group conditions. Others get so excited over it that they make it difficult for everyone to participate, and thus evoke hostility and rejection. Also limiting the general usefulness of this technique are individual differences in the ability of different therapists to exhibit that flexibility of participation in the play drama activity, which may have to range from that of a spectator-onlooker to that of taking a star or central role.

All role-playing techniques require a therapist capable of a certain amount of personal modeling and empathetic dramatization, which inspires the others to throw themselves into this type of activity. In the modern American culture where, as social anthropologists (Mead, 1949) have pointed out, exhibitionism is considered feminine or childish, it is unlikely that many psychotherapists will use this technique without reservation. On the other hand, since in European countries the adult is the central play figure and the child-spectator quietly waits for the later privilege of exhibitionism, psychotherapists identifying themselves with a European cultural heritage will most likely find a personal affinity for role-playing techniques.



**5. A Theoretical Paradox of Role Playing as a Therapeutic Procedure.** Social learning must be distinguished from intensive psychotherapy. The psychotherapy of emotionally disturbed patients is a different task from training normal individuals to function more effectively in new or difficult social roles. Bradford (1948) and many other dynamically oriented group educators utilize role playing for learning social skills in leadership and teacher-training workshops. When role playing is used for the further education of the presumably adequate person, the emotional, defensive, and wish bases of role playing are never analyzed. In the leadership training shop, the unconscious factors are left alone; roles are analyzed only from the point of view of their effectiveness or ineffectiveness in increasing the leader's and the group's efficiency, morale, and other factors. In intensive therapy groups, role playing is not used in this restricted training sense, except, perhaps, under special emergency situations. The effectiveness of social skill training for individuals whose life adjustments are sufficiently effective so that they are not in need of intensive psychotherapy cannot be expected in the treatment of neurotic patients. If experience shows that role playing may not be therapeutically effective, why is it so popular? We have already examined why the role-playing technique is popular with patients.

In the opinion of the author, so-called "role playing therapy" is appealing to professional clinicians and researchers primarily because of its logical and theoretical "neatness." The idea that psychopathology is the same as "ineffective" living, that it can be cured through "social role training," is a neat concept which has attracted many educational and social psychologists. But many clinical psychologists and psychiatrists, charged with the rehabilitation of psychosomatically and emotionally disturbed individuals, are skeptical of the true clinical value of role playing when it is thought of as an independent and self-sufficient approach to psychopathology. We see in private psychotherapy practice a great many psychosomatic patients suffering from many kinds of physiological ailments. Many of these patients are extremely efficient and realistic in living their social-economic roles. Many of our economically successful patients have very

excellent social skills in real life. What disturbs most neurotic patients is that in spite of their adequate social adjustments, they still have very serious inner and interpersonal problems which keep them in a state of inner tension. For the therapeutic management of the manifest socially adequate patient much of the ideology of role-playing therapy seems to be beside the point.

What of the obviously nervous, shy, withdrawn, schizoid patient who certainly could benefit from and would like very much to improve his social roles? In their case the danger of taking role-playing therapy too seriously as a basic therapeutic approach rather than considering it as a limited therapeutic adjunct lies in the danger of reinforcing a superficial, basically defensive emergency and fantasy-reaction (role playing) as a mode of life. Such a procedure would not touch or work through the conflicts which kept the patient's role in an undeveloped or impaired state in the first place. It is clinically naïve to believe that rather disturbed patients are capable of improving their "social skills" without first understanding the deeper motivational significance of their lack of them. In psychotherapy one must *first* pay attention to the removal of unconscious blocks in the patient against a healthy and natural growth in social skills.

The above considerations will make it clear why, within our own approach, we assign to role playing a very specific and limited place. As far as learning social skills is concerned, we acknowledge its value in educational situations with average individuals, but are quite sure that the theory underlying educational psychology and depth psychotherapy, while overlapping in many respects, have very different processes to explain and to control. The differences in purpose, function, and task between the psychologically sound education of the normally growing person (child or adult) and the purposes, functions, and tasks of psychologically sound rehabilitation work of individuals *not* maturing normally or of individuals in traumatic stress situations, make it dangerous to apply, uncritically, theory and methods applicable in one set of problems to the other set.

## Chapter 11

### GROUP AWARENESS: SANCTION AND SELF-REGULATION

---

In our group-centered regimes of participative psychotherapy, members do not repress, as they often do in work and family groupings, their awareness of the group life processes which they are affecting and by which they are affected. Studying the recurrent issues, i.e., the latent conflicts with which individual patients are repeatedly concerned in the group setting, Varon (1953), working as part of Powdermaker and Frank's (1953) research team, found that such phenomena as status, role, active versus passive mode of communication, and conformity versus rebellion, were regularly recurrent in all therapy groups. There are, in other words, issues inherent and endogenous to the social processes of group therapy. The discovery of constant reoccurrences, of communications manifestly or latently concerned with certain issues arising from the group life itself, motivates the patients to give overt expression to conflicts arising from group living itself. Such expressions remain latent and unexpressed in ordinary social communications and they have no occasion to be examined in the individual therapy setting. The opportunity to become aware of one's effect upon a group and the reciprocal effect of group dynamic processes on present adjustment appears then to be one of the unique therapeutic experiences instigated by group therapy participation.

The experience of expressing participant observations of the group life, is of strong therapeutic significance to the patients in a therapy group. The theme "awareness of group process and role" (Theme 9) occurred in each of the one hundred meetings of both sample groups. In our program this theme occurs at

least once in every meeting. Actually, the experience of group process awareness, and of communicating such awareness is a by-product of all communications between group members.

Many human groups still function like Freud's (1930) imaginative model of the "primal horde." In any autocratic, hierarchically structured group, such as the "old-fashioned" European family, the form of participation of its members—their roles—is determined by the unsanctioned power and authority of the leader. Psychotherapy groups do not simulate such a primitive group structure, for autocracy, as Lewin has shown experimentally (Lippitt & White, 1947), is not conducive to full member participation and communication. The psychotherapeutic process of individual ego development flourishes only in a participative, democratic group in which all members continuously define and redefine member and leader roles. Certain group techniques used in our practice facilitate the growth of such a democratic-participative group atmosphere. In this chapter we shall describe various techniques which, as a whole, encourage the development of the group's latent capacity for self-regulation. From a clinical standpoint, these techniques are designed to make it easier for each individual patient to be fully participative in the regulation of the life of the therapy group. From our follow-up studies of former patients we have gained the impression that sharing in the clinical management of the group is a therapeutically beneficial experience for the patient.

Certain factors have been recognized as enhancing democratic group morale. Among them is the feeling of security obtained by members from habitually practicing group problem-solving activities (cf. French, 1950). Hemphill and Westie (1950) have shown indications of ego growth mediated through training in observations of group dimensions. The various group therapy techniques which are repeatedly used by our groups to facilitate the solution of in-group problems improve the *esprit de corps*. Through the use of participation-stimulating techniques, a shift of group atmosphere from leader-dependency to self-recognition, from regressive-recapitulative to progressive-expansive emotions occurs.



## Leader Role and Group Sanction

In our approach, a continuous sanctioning process of leader-originating suggestions occurs. The total group participates either through silent or expressed group sanction. This helps the group to overcome clinically undesirable leader dependency patterns. Group sanction is implicitly applied to all members regarding all activities that affect the group's progress. The group therapist, the official conductor or "leader," has a role in the group which is interdependent with the force field created by a democratic group. A. T. M. Wilson's (1951, p. 21) distinction between *sanctioned authority* and *unsanctioned autocracy* helps to clarify "member participation" and "leader role."

... a differentiation is made between sanctioned authority and unsanctioned autocracy. Sanctioning is a cultural process by which power is linked to authority. Power is an attribute of an individual or group—the strength of influence he or it is capable of exerting through skill, knowledge, group cohesion and other factors. Authority is an attribute of a role and is definable as what may be done in a role.

In terms of such definitions, the following formulation of the concept of participation is possible. The act of participation may be regarded as taking a role in a social system. As to the conditions affecting full participation, first, there must be the offer of a role, and freedom to choose a role which is acceptable. The role itself then requires sanction from *above*, from *below*, and from *within* the individual or group. Finally (and this is the more limited sense in which the term participation is usually employed) there needs to be an opportunity to take part in prescribing the authority, position and other attributes of the role taken, and in deciding the policies governing the day-to-day operation of the role. . . .<sup>1</sup>

When we apply the definition of sanctioned authority to the position of the skilled psychotherapist in a therapy group, we can see that the authority of the therapist is derived from his skill in influencing the group members toward the most effective ways of getting the therapy work done. From his extensive training in psychodynamics and interpersonal relations, from his research and clinical experience with groups, the therapist must

<sup>1</sup> Quoted from A. T. M. Wilson, Some aspects of social process, *J. soc. Issues*, Supplement Series, No. 5, by permission of the publisher.

accumulate a high degree of skill and specialized knowledge. It does not take a participative therapy group long to discover how best to utilize the special skill of the therapist.

One factor reinforcing the group's use of the therapist's special training is the pain of emotional anxiety experienced in therapy group participation. According to Bion (1948-51), Hobbs (1951), and other experienced group therapists, the role of the therapist is to help the group alleviate, manage, and work through tensions and anxiety which are generated by the group life. The average patient realizes from his own participation in the group that the expert's leadership is at times necessitated by high levels of tension.

The therapist's authority is sanctioned by the nature of his task; it is sanctioned in the same way that highly skilled experts in industrial settings derive authority from their tasks, because they require high degrees of precision, and extreme specialization. Jaques (1951) has labeled this process *task-sanction*. Jaques has shown how the hierarchical power and authority structure of a modern factory will be sanctioned by the participants as long as it expresses correctly various degrees of authority in relation to technological efficiency. The clinical technology of the group therapist derives authority from the fact that without this technology the therapeutic progress would suffer and group tensions would be too high. Experiences of anxiety are peculiarly entrenched in free participative communication. The group will sanction the authority of the therapist in guiding the group toward certain activities and communications, and away from other types.

### Fear Reduction and Authority

Patients have two fears which they expect the therapist to reduce: (1) therapeutic progress may not be made, and (2) the tension and anxiety level may become too high for individual tolerance. To the extent that the psychotherapist effectively helps members of the group to master these fears he has "authority." By the same token, any other member of the therapy group who, by contributing what clinical technology he intuitively

tively may possess, effectively reduces these two fears, gains authority and power in the group. Conversely, any member who behaves in such a way as to reinforce these fears does not have any authority or power in the group.

Of therapeutic significance is the self-evident relationship between being able to function effectively within a therapy group and in outside, regular social life. Ego-development and low anxiety, two explicit goals of the therapy group, are implicit goals in all human relations. In order to master these goals in the therapy group, opportunity must be afforded to recognize and to give expression to the recognition of the role contributions of the therapist and of every other member of the group. Techniques of communication, such as group decision formation, provide the opportunity to discover, to assess, and to sanction every individual's role in the therapy group organization.

### **Examples of the Group's Self-Regulation of Programs**

Program planning is done by all members of the group. The group therapist does not rigidly anticipate what kind of program a group meeting should have. He, in fact, does no advance planning for a meeting. He has no "order of business." In other words, program planning does not imply a long-range or rigid system. Rather, when programs are used, they are the answer to the group's questions concerning how "to get started," "warm up," or "break the ice," during the initial twenty to thirty minutes of a group meeting. Different groups vary greatly in the use of "warm-up" techniques, some of the more intensive groups hardly ever making use of them while the less frequently meeting groups find them helpful in bridging the interruptions in the group mood and culture due to the longer intervening time between meetings.

The making of group decisions to use or not to use programs is an example of the group awareness of a process of assessing group needs and managing them in response to the assessment. The clinical significance of group awareness, assessment, and decision derives from the fact that group consensus is a major

factor in the therapeutic learning process of the individual patient. The procedures that groups engage in are not simply motivated by a "group-centered" or democratic philosophy, but have a therapeutic rationale: the formation of explicit group attitudes and majority perceptions is a most potent psychological force toward change of the individual.

**Reaction to Therapist's Suggestions.** The therapist may suggest an activity or theme, but it is always implied that the group can exercise its prerogative to sanction the suggested direction or to refuse to go along.

PROTOCOL NO. 14: REACTION TO A  
THERAPIST'S DIRECTIVENESS

Therapist: All right. What's next? Who has something to bring up?

I-F: E-F was going to tell a dream.

B-M (addressing Th.): A-M started to say something and you cut him off.

[Group conversation in which all agree that the therapist did cut a patient short.]

Th.: You don't like me to cut off anybody.

Group: No.

Th.: I shouldn't cut off anybody, huh?

B-M: Well, yes, under certain conditions, but this time A-M had some feelings about something. This wasn't just . . . this was . . .

[Group conversation debating whether the therapist was arbitrarily directive or not.]

Th.: Okay. [Pause] Don't let me get away with anything here. I shouldn't interrupt.

D-F (to A-M): What were you going to say?

B-M: Boy, you better have something good to say now.

[Loud group laughter]

G-M: We were defending your right to say it, now say it!

[Laughter and pause]

Th.: See, that just goes to prove that I was wrong, because my interruption of A-M apparently squashed his association.



D-F: But did he have any, or was it B-M's grasping at anything to catch George [therapist] doing something "bossy"?

[Group conversation and laughter]

B-M: In fact, I do resent your cutting people off. I feel this is a big group, and I don't like it when you cut A-M or anybody else off.

H-F: That's a little different from your usual feelings about A-M being cut off. Usually you get very impatient with his speeches.

A-M: That's right, it is.

Th.: Yes, any material will do to put me in my place—any material.

B-M: But I know you do cut him off particularly. Sometimes I guess it's a good thing.

[Laughter]

Th.: All right, I noticed it too. It is true. In fact, A-M and I have discussed this in a private session. We have a sort of agreement. The group doesn't handle his tendency to dominate its attention. You won't handle him. In fact, you sit back and let him get going, then later complain. I wish the group would help A-M with this problem.

B-M: Yeah, but he doesn't do it any more.

G-M: I feel it is the group's responsibility, not just George's or A-M's.

H-F (to B-M): I can't stand your hostility to George. You pick on him!

B-M (to A-M): Well, say something now, will you?

H-F (to B-M): Well, see that he shuts up. He was going to tell us nothing. You just want to pick on George.

Th.: No, I think B-M brings up an important feeling. Let's examine it.

I-F: E-F's choking over there to tell her dream, and . . .

The therapist's role is always of great interest to the group. The effectiveness of the group therapist is increased by the group's making explicit their awareness of his effect on them and their explicit expression of what they consider the best role for the therapist in any given situation.

**Choice of Warm-up Techniques.** The next protocol is taken from Group I at the beginning of a session. For several weeks previous to this particular session, Group I had had periods dur-

ing which the patients experienced acute difficulties in communication. Such difficulties are more common with the once-a-week groups because the freedom of verbal communication, which is practiced in the more intensive therapy group, is interrupted by a whole week of the repressed type of communication usual in daily living.

After struggling for a while with this problem, during which they considered meeting more frequently than once a week, the group made the decision to start each session with a communication warm-up or icebreaker program. They decided to write each one of the following "programs" on a separate card and then have the first patient who came to the group meeting pick from a bowl the activity which the group would use to start with: (1) telling dreams, (2) psychodrama, (3) drawings, (4) going around, and (5) projective tests. They had adhered to this decision for a few meetings when at the meeting which this protocol describes there was for the first time strong resistance against the use of these initiating or warm-up activities. Some patients felt that the group no longer needed them, but others were opposed to discontinuing the procedure.

This meeting contributed toward a series of steps which ended in the abandonment by this particular group of all warm-up techniques. At this point patient A-M left the group for the third time. (At the time of this writing he is back again.)

In the protocol members refer to *going around* (Theme 14). This theme consists of having each person in the group express verbally how he is personally and emotionally affected by the neighbor seated to his right or to his left. This routine is used in new groups particularly until the members are able spontaneously and continuously to give an unrepressed expression of how each person is emotionally affected by every other in the here-and-now group situation. Group I found, among the five activities, that going around was the most productive and helpful. Going around was the most popular of all the activities, owing to the obviously reliable effect of stimulating interpersonal communication on a nonstereotyped, personal level. The following protocol illustrates how patients get emotionally involved in details of the group life process.

## PROTOCOL No. 15: TO GO OR NOT TO "GO AROUND"

[Group I: eight members present, three males and five females.]

H-F: We had agreed last week that we would have the "going around" this week.

Therapist: Well, is there any reaction to the hesitation tonight to get started with the going around?

B-M: I'm perfectly comfortable.

G-M: I feel very relaxed. I don't want to analyze anybody.

B-M: I'm also comfortable. Perhaps we do not want to disturb this.

E-F: I regret to say I feel that way. Just comfortable.

Th.: We're all comfortable?

[Long silence]

H-F (to Th.): Well, I can't stand this jacket of yours.

E-F: Isn't that awful—plaid and then a maroon thing to top it off.

[Multiple conversation among women and laughter cynically directed at therapist's attire.]

D-F: Oh, let him alone. He's comfortable.

[Laughter and conversation among women]

E-F: We would rather talk about the clothing than anything more dangerous.

[Conversation among women]

Th.: What's the group avoiding?

D-F: I'm ready to go around, although I know a couple of dreams I'd like to tell and I think the group is ready to work on dreams without the warm-up tonight.

Th.: How about that? Who else feels ready to go into that?

H-F: Okay.

I-F: I also am interested in myself.

D-F: And my problems on the outside are pretty acute this week.

Th.: Have you noticed that A-M looks displeased? Do you like to dispense with the warm-up period, go right into dreams tonight?

A-M: No, I don't think we should make any deviation from our usual set-up and what we decided as a group.

[Laughter and multiple discussion in which it was mentioned that warm-ups are used only when necessary and that A-M should not be so rigid about that.]

A-M : I still think we should go around.

H-F : All right, start it. Go around. Start talking, A-M !

A-M : Why pick on me ?

H-F : You're the one who wants to go around.

A-M : I'm the one who starts everything. That was a group decision, not my idea !

D-F : Well, I don't think it's a question of deviation. I think if it's going to be used as a warm-up period, fine, but if you don't need it, why do you have to use it ?

A-M : Don't you think we need it ?

Group : No.

I-F : I don't think we do.

Th. : Well, apparently, the majority of the group feels they don't need it, most of them don't need it any more. Is this so ?

H-F : A-M feels he needs it.

I-F : Why do we have such a slow start tonight. I have lots on my mind ! I think he is trying to force us. He always wants to do drawings and psychodrama and such things.

Th. : How about that, A-M ?

A-M (to I-F) : What you mean . . . I mean right away I think you want to control me ! If I give in and make everyone happy, I'd be hostile anyway. Don't you see ?

[Pause]

D-F : Oh, now we're getting down to the bottom of the hole.

A-M (to the women) : And right away I'm hostile to your decision to control the group. So far tonight the men have said nothing except that they feel fine. [Laughs]

I-F : You just named three, and you're right in the middle. [Laughter] And I mean it literally. Oh, brother !

A-M : Well, that's what I felt. The women here were perfectly anxious to drop the going around, and go into something that they felt they could control. So it threatened me as far as the power of women's voices is concerned, and that's what made me shy from going along with them, I think.

Th. : Any reactions to A-M's self perception ?

B-M : I think A-M has a good feeling for the way he sees danger in the girls taking over the group.

D-F : He resents any authority figure in a woman. I mean any woman with any authority, and that he thought the three women were trying to dominate the group, and he didn't want any part



of it. Anyway it was a group decision that tonight we did not need the warm-up. It was not just the opinion of the girls.

A-M: We didn't. B-M didn't say a word about it. The men did not decide anything.

E-F: Yes, B-M did. He did.

I-F: He said he felt quite comfortable.

A-M: I'd just as soon hear that it was something else, a more honest reaction!

B-M: I said something about it, yes. I was ready to talk about dreams.

I-F: E-F and D-F were not particularly interested in someone else's problems tonight because they have rather pressing emergency problems. Instead of dominating they were more or less asking, "Do you mind if we sort of discuss our problems, right away?" That is my reaction.

[Pause]

E-F: It didn't strike me until now that the men were passive and that we were pushing the going around idea out of the way.

B-M: I can see the viewpoint now. It didn't occur to me before. I can see how A-M would react to that now.

[Pause]

Th.: Well, now that we have chewed that through, what's the group's decision?

I-F: Well, let's find out D-F's dream and dispense with the warm-ups.

B-M: Well, I was going to say if A-M wants to pick somebody, to analyze somebody, that's fine.

H-F: Yeah.

A-M (to Th.): Did you start going around, now?

Th.: No, I'm not telling the group what to do. We were just having a discussion. The group is not clear yet. But B-M has a suggestion. What about that? This is a group question. Some of you here said you were all ready to start working on dreams. This is a group problem. The group halted at this point. Why?

B-M: A-M analyzed it, saying that it was probably because the three girls here seemed to him to be deciding what the group was to do, and that is why I don't fall in with the majority feeling, that we can do without going around or the other warm-ups. We have enough material ready to do a quick go around.

A-M: Yeah.

D-F: It makes no difference to me.

G-M: Well, first I think if A-M has something to say on the subject, he ought to say it.

A-M: I didn't have any particular reason in . . . The only thing I was interested in was talking it over, that's all.

Th.: Maybe we can work this through a little bit. In other words, the interpretation is that you, A-M, are threatened by this quick change today. You like the warm-up exercises, don't you?

A-M: I like to feel that we have direction, a program, something to bite my teeth into, but I don't like it so methodical that we can't deviate. No. But when we once arrive at a decision to use it, we should stick to it. Everyone decided on the going around situation because it was easier to get going and they liked it. Now this is about the first they feel ready to go without a warm-up! Remember the many weeks that the group struggled to get going? That's why we decided to have these warm-ups anyway. It isn't I who has the trouble to get going. I always have something on my mind. Now everything seems to be reversed and that is why I feel that it isn't because H-F and E-F and D-F are ready to start without help. Rather, they just want to dominate the group because they were the ones who were the most defensive in the first place. I always discuss my feelings freely—maybe too freely, like now.

H-F: I agree with you, A-M. I think you're absolutely right in the history of the thing.

[Group conversation among females]

H-F: I think he's absolutely right. Last week we decided that tonight we would start with these warm-ups.

[Group conversation and laughter]

A-M: I'm not going to scold the group, but after all I think we need the stable, continuous process of our going around, drawings, etc. I gave in before, you know, in the fact that I wanted the psychodrama and everything else. That was strictly my personal opinion because I really felt that having different warm-ups gave us a flexible situation, nothing that we would prepare or anything like that. We should catch ourselves off hand. That's good therapy. The group didn't like that. They wanted going around every time, so I gave in on that. Now they want to break up the going around tonight, and I felt that there isn't

any stableness in this entire deal at all. In other words, it's just about what a pressure group, or the lobbyists, rather than the entire group decides to do. In this case the powerful lobby is the women here. [Group conversation] So I give my opinion. And right away I think the power of this particular pressure tonight comes from the power figure of women. And I acknowledge and admit it. I know it's neurotic all right, but I'm frank about it.

[Group conversation]

G-M: I don't see why we should be bound by any one routine. If you want to have psychodrama sometimes, you could just say so, and . . . [Female conversation] Well, you can suggest a situation. There's no reason why we shouldn't do these warm-ups more spontaneously.

H-F: It isn't a question of being bound. [Group conversation] But last week we agreed.

[Very emotional group conversation]

I-F: I think A-M is threatened by the lack of an authority figure with this particular problem. He wants an authority to enforce a program.

A-M: Yeah, that's right. That's a deep problem for me.

H-F: Then let's go around.

D-F: I think that would be the best solution to the present tension.

H-F: As we agreed last week.

It is obvious to the dynamically oriented clinical observer that many unlabeled, unconscious processes occurred beneath the manifest communications given in the above protocol. Another way of saying this is to point out that labeling the communication in terms of group process awareness does by no means exhaust one's understanding of the interpersonal dynamics. The above protocol will have served its purpose if it has helped to illustrate, even in a fragmentary way, what we mean by group-centered, participative atmospheres which include the sanctioning by the group of the leadership role.

From a clinical standpoint, the protocol is rather interesting in the sense that it illustrates the stimulus value to a group of a paranoid schizoid patient (A-M), whose struggle with adapta-

tion to reality and to his paranoid (latent homosexual) delusions vis-à-vis the "powerful world of women" is clearly externalized on the stage of the life of the therapy group. While most of the patients in the group are in the dark concerning the underlying dynamics (in comparison to professional understanding), nevertheless quite a number of the patients intuitively sense the difficulty that A-M has.

Interesting, also, from a clinical standpoint, is this patient's wish for "flexibility," a manifestation of a counterphobic defense against his pathological need for structure and his authority-riddenness. While lay patients do not have professional training which would enable them to recognize these pathological patterns *quickly*, they will learn to recognize them over the long period of time a continuous group is in session. When insight comes, it originates in the patients; it is then more effective than "cure by authority."

### Psychometric Assessment as Technique to Facilitate Self-Awareness (Theme 10)

Several dynamically oriented group therapists pay close attention to the way a patient will assess the group attitude toward himself, for in such attitudes he externalizes his neurosis. In addition to this clinical personalistic frame of reference, the assessment of interpersonal effects in the group is an important object of study, not only for the group therapist, but for the patients themselves. In the words of Bion (1948*b*, p. 488):

. . . the way in which men and women in a group make these assessments is a matter of great importance to the group, for on the judgments that individuals make depends the efflorescence or decay of the social life of the group.<sup>2</sup>

Fortunately, from a technical standpoint, social psychologists are also quite interested in techniques and processes by which face-to-face groups become aware of themselves.

It is well recognized by students of group life, such as Gibb, Platts, and Miller (1951), that the continual assessment by the

<sup>2</sup> Quoted from W. R. Bion, *Experiences in groups*, *Hum. Relat.*, 1, 488, by permission of the publisher.



group of its own activities is an essential condition for the evolution of a participative, democratic group culture.

Such assessment may follow several techniques. For this purpose a special observer is often used. He may be either an assistant to the therapist or a member who is assigned the task of continuous observation of group activity, which he may summarize at the end. Such observers may gear their discussions to particular aspects, such as factors that increase unreleased group tensions. Observation may or may not include suggestions as to relief of tension. Such reports may go along the lines of observed pairing and subgroup structures, or they may go along the lines of reporting the manifestations of individual idiosyncrasies of patients. It has been noted by Gibb a.o. (1951) that the appropriate timing of evaluations of group activity is highly important and facilitates the smooth communication of face-to-face work groups.

To avoid the creation of a group culture characterized by a split into those who are observed and those who are observing, in our intensive group psychotherapy program these functions of a professional group observer are taken over by the group itself. In our group therapy setting we like to have everyone participate in observing and being observed, and in expressing and communicating, both experiences fully without relying entirely on a professional guide. The reason for using observers, namely, to facilitate democratic processes, has been found in our experience to "backfire," insofar as a professional observer further strengthens the already strong dependency of neurotic groups on "being helped by the expert efforts of a leader."

At the Research Centers for Group Dynamics and Human Relations at the University of Michigan, the University of Minnesota, and at Harvard, experience has shown that study of the deeper nature of group processes is facilitated by revelations made by group members when engaged in an assessment process. "Hidden agendas," that is, nonrationalized feelings about the group and projections of the group goals and purposes, are revealed. Self-evaluations arouse discussion and interpretation, and activate groups.

The fact that experimental subject groups *can* reveal dynamic processes gives support to the possibility of helping patients to become aware of the reality of group dynamic processes. Such awareness, representing as it does, increased perceptual acuity of social reality, is, in our regime, one of the therapeutic goals. Reaching this goal helps neurotics to reduce anxiety-evoking vagueness and lack of structure in many social situations, where life demands that the patient be a functioning group participant, as in his work and family groups.

The use and analysis of "assessment" data is a good example of group culture-building activity. This and other group programs help to make the group conscious that *they are the group*, that the group is not made up simply of one leader and several followers, but that from an emotional point of view experiences other than "following" or "leading" may consume the interest and energy of its members. One way of making explicit these feelings about each other is the adoption in modified form of a sociometric assessment technique, which was used four and six times, respectively, during the one hundred meetings of Groups I and II.

In addition to serving the enhancement of in-group orientation and group-centeredness, assessment techniques have a therapeutic rationale in terms of discrimination learning. Patients referred for psychological treatment, whether they are character neurotics or belong to the group of psychosomatic disorders, are characteristically prone to commit errors of perception in judgment in interpersonal relationships. These errors, when repetitively committed, interfere seriously with the psychosomatically maladjusted person's recovery; for in order to become psychologically rehabilitated, the conflicts these patients experience in interpersonal relationships with friends, mates, superiors, and employees must be resolved.

When interpersonal conflicts are resolved, the intrapsychic struggle, that is, the build-up of emotional tensions within the person, is also reduced. Group psychological treatment helps patients to become aware of the nature of these distortions in their social perceptions. Distortions as to how other people feel

and react to oneself constantly reinforce experiences of conflict and frustration in one's relation to others. Frequently, the notions that patients have about others' reactions to them are highly distorted, without the patient being aware of such distortions. Group assessment is a technique which has been found useful by the writer as an adjuvant for the purposes of helping the patient to locate the major areas of his perceptual distortions in interpersonal traffic.

One form of this procedure consists of acquainting the members of the group (after the initial twenty sessions have passed) with a sociometric questionnaire for group therapy assessments (given on the following pages in an abbreviated form). After each member has a chance to glance over the material, the therapist states the purpose of the procedure: "It might be useful to know not only that we tend to make mistakes in the perception of other people's reactions to us, but also it may be helpful to see what kinds of mistakes, in what areas of our relation to others, we tend to make the most mistakes." The therapist next seeks a group decision as to whether or not and when to have what type of questionnaire made up and filled in individually, and brought back for purposes of the "assessment." Collecting the filled-in questionnaires is an occasion for airing feelings experienced in making the sociometric choices for the clinical and social evaluations required in the questionnaire. At this time the members express curiosity concerning how other people answered certain questions, and the therapist encourages them to make use of this motivation in attempting to guess or predict who chose whom for what.

The sample questionnaire given below was developed through many editions over a long time by the members of Group II. It is one of the most elaborate sociometric questionnaires produced and used by any therapy group in the experience of the author. It reflects the high educational level of the population in Group II. At present, when other groups decide to use a sociometric group assessment, we make copies of this questionnaire available to them and encourage them to modify it to make it more meaningful for their own purposes.

## SOCIOMETRIC QUESTIONNAIRE FOR GROUP THERAPY ASSESSMENTS

(Second Edition, revised September, 1950, by V.K. and E.D.)

### PART I

#### INSTRUCTIONS:

Write your full name here .....

Below you will find several confidential questions concerning your feelings and attitudes, and your evaluation of other members participating with you in your group therapy program. In each case you are asked to write in the name of a member (or members) whom you would choose or evaluate in the manner indicated by the question. Include in your choices yourself, the therapist, and members who are absent either temporarily or permanently. If, in answer to some of the questions, your preference is for yourself, do not hesitate to put your own name in the space provided. "Nobody" or "Everybody" may be used if appropriate.

After you have read the above instructions carefully, proceed to answer each of the questions below. Make your decisions without hesitation and *give the first answer that comes to your mind*. If you have difficulty in answering a question, skip over it and try again after you have answered the remainder of the questionnaire.

This material will be kept confidential by the therapist in charge of the group and will be discussed only if the group agrees to do so.

1. Who is most like yourself? .....
2. Who is least like yourself? .....
3. Who is easiest to talk to? .....
4. Who is most difficult to talk to? .....
5. Whom would you like to have with you in time of danger? .....
6. In whom can you confide? .....
7. Whom would you like to take with you if you anticipated having to face a difficult social situation? .....
8. With whom would you like to share a room or apartment? .....
9. Whom would you choose to work with? .....
10. Whom would you choose to have fun with? .....
11. To whom would you turn with your personal problems? .....
12. Who has less serious problems than you? .....
13. Who has more serious problems than you? .....
14. Whom would you like to have as chairman in making group decisions? ...



15. Who do you feel blocks or diverts the group's therapeutic work? .....
16. Who is most defensive about seeing his own problems? .....
17. Whom would you like to help most to see his own problems? .....
18. Who do you feel brings up the most useful material with respect to your own problem? .....
19. Who tends to bring up sexual problems? .....
20. Who tends most to stimulate fun and humor? .....
21. Who is the most forward toward the opposite sex? .....
22. Who tends to probe into the intimate experiences of others? .....
23. Whose hostility could you tolerate most easily? .....
24. Whose hostility could you tolerate the least? .....
25. Whom do you consider the "best" group member in terms of making a real effort to solve his or her problems? .....
26. With whom would you be the most afraid to disagree? .....
27. With whom would you be the least afraid to disagree? .....
28. To whom would you most likely turn if you needed support in the group? .....
29. Whom are you most likely to protect if he or she is attacked? .....
30. With whom do you most often agree? .....
31. Who agrees most often with you? .....
32. Who is the most independent personality? .....
33. Who can out-argue you? .....
34. Who threatens you the most? .....
35. Who is the most socially attractive person? .....
36. Who is most attractive to you sexually? .....
37. Who is least attractive to you sexually? .....
38. Whom would you most like to have as a friend? .....
39. Who is least attractive to you as a friend? .....
40. To whom do you think the therapist pays the most attention? .....
41. To whom do you think the therapist pays the least attention? .....
42. Who most consistently seeks group approval? .....
43. Who most consistently seeks group attention? .....
44. Who most consistently seeks the therapist's approval? .....
45. Who most consistently opposes the therapist? .....
46. Who is the most aggressive group member? .....

47. Who is the most passive group member? .....
48. If a secret ballot were taken to eliminate one group member, whom would you vote to eliminate? .....
49. Whose elimination from (or departure from) the group would disturb you the most? .....
50. Name those who you think pair up or clique together? .....
51. If it became necessary to divide the group into two parts, how would you divide it? Whom would you like in your part? .....  
Who would be in the other part? .....
52. You are asked to select the cast for a dramatic scene of family life. Select from the group (including yourself and the therapist) individuals to fill the roles you think best fit them:  

For Mother .....	For Younger Brother .....
For Father .....	For Younger Sister .....
For Older Brother .....	For Baby .....
For Older Sister .....	

## PART II

### INSTRUCTIONS:

In this part you are asked to complete the unfinished sentences *with the first thought that comes to your mind*.

1. The group would be very much improved if .....
2. By the time I finish with my therapy, in about ..... months, I expect to be able to .....
3. The thing that annoys me most about the therapist is .....
4. I would leave the group if .....
5. I feel that our best sessions occur when .....

## PART III

### INSTRUCTIONS:

Below you will find questions of similar content to those which you answered in Part I. However, in these questions you are asked to guess or predict how the other group members will choose or evaluate you. In the open spaces be-

low place the name of the member who you think will choose you in answering the respective questions in Part I of this questionnaire.

Make your decisions without hesitation and *give the first answer that comes to your mind*. If you have difficulty in answering a question, skip over it and try again after you have answered the remainder of the questionnaire.

1. .... thinks that I am most like him/her.
2. .... thinks that I am least like him/her.
3. .... thinks that I am easiest to talk to.
4. .... thinks that I am most difficult to talk to.
5. .... would like to have me with him/her in time of danger.
6. .... thinks that he/she can confide in me.

[Questions 7 to 52 are as in Part I, modified in the manner exemplified by the first six questions given above]

## P A R T I V

### COMMENTS AND SUGGESTIONS:

.....  
 .....  
 .....

The tabulated contents of the sociometric questionnaires can be of great help to the therapist, for they give many valuable clues to the dynamics of the group, as well as such clinical dynamics as the nature of negative or positive transferences toward the therapist, the nature of subgroup divisions or cliques, and the location of isolates and rejects. In our technique, the therapist does not discuss the results of his own study of the material. He simply accepts the value of such information in increasing his own understanding of the group.

The tabulation of the answers to the questionnaire reveals the extent of wrong guesses. As the guesses are checked against the actually collected answers, the group usually detects some members who make "typical" mistakes. This is subject to discussion as to why, for example, N-M constantly makes errors when it comes to questions involving criticisms of others, and why U-F is so accurate when it comes to the appraisal of questions of sexual significance. The therapist encourages the patients to express what surprises, if any, they are experiencing as the results are coming in. Some patients experience strong trauma when they find themselves not as frequently chosen in a favorable way

as they had anticipated, or when they are chosen in roles which they never associated themselves with.

Equally frequent are reactions of pleasant surprise, which are registered by patients who have underestimated their popularity in the group. However, much anxiety is usually evoked by this organized and concentrated method of reality testing, so that the technique can backfire on the group unless each step is taken with complete group understanding and group sanction. For group consensus is the *deus ex machina* that solves most effectively clinical management problems arising from excessive anxiety and tension evocation. The individual will yield to the reality established by group consensus.

Symbolic role assignment is one example of the type of perceptual products of group consensus. During the informal phase of discussing the assessment data, there usually emerges an assignment of a role to each member, which has primarily a symbolic or unconscious significance. The fact that the labels for these symbolic roles are extremely similar in very different groups with different therapist influences suggests that the group perception has some realistic significance. Some of the most common role labels which members who have known each other for a relatively long time may apply to each other during the discussion session include father, policeman, the masculine one, *femme fatale*, baby clown, the dangerous-seductive father, "teacher's pet," "therapist-assistant," the reality principle, "sexy," the very sick one (mentally), the masculine protest (castration figure), the perfect mother, the evil rejecting mother, "four flusher," the p-teaser, the intellectual, the artist, the silent one, the *casanova* seducer, the homosexual, "the les," the puritan, "Mr. Duty," and "Miss Fun."

Discussion by the patients with the therapist usually brings out fairly clearly two bases for these symbolic role assignments: First, the fact that they are products of group consensus shows that the role label in part reflects how the patient's personality, that is, his manifest defenses, actually affects the others in the group. Secondly, therapy groups seem to want to assign symbolic role labels, as they do so whenever the manifest behavior of a member shows some characteristic response pattern suitable



for a label. It seems that the group assignment of a symbolic role is an expression of the unconscious wish to provide for suitable operations to act out on others certain emotional needs. For example, if a patient behaves in ways suitable to earn the label "therapist-assistant," the group will try to keep him on this role. A possible explanation for this phenomenon is that all welcome the opportunity to act out Oedipal rivalry feelings on the role carrier, with whom this particular role never sits well. We have already noted that the silent one serves well all projective needs of the other members. With the "very sick" one can play doctor, and other symbolic roles permit the release of different unconscious longings. From the standpoint of group dynamics, the process of symbolic role assignment reflects and strengthens the cohesiveness of therapy groups.

Following the more or less informal discussion of the questionnaire results, the therapist usually asks for volunteers who will make a more formal and accurate tabulation of the results. In this procedure each patient is given an acceptance score. The acceptance score is the number obtained by counting the number of positive choices and subtracting the number of negative choices. Here again a group may define its measures differently. One group developed a "neurosis" score which was a rough index of the degree of over-all distortion of social perception which a patient may have in his predictions of the sociometric choices of others concerning him.

In one very sophisticated group, the material was also analyzed for a so-called "projective score," which is a percentage obtained by dividing the number of correct predictions or guesses in Part III (of the sample questionnaire), by the total number of guesses made. The projective score was further subdivided into three areas of "hostility," "sex," and "therapy." Projective scores were given relative to each of these three areas, in addition to a total projective score. For example, a patient may have an over-all projective score of 50 per cent correct predictions. His subscores may be as follows: hostility, 10 per cent; sex, 60 per cent; statements involving therapist's attitude, 60 per cent; and lack of defensiveness, 80 per cent. The group felt that this patient tended to commit his greatest distortions of social reality

in situations involving the judgment of his own and other people's hostilities. The patient can then see that he is particularly sensitive and "maladjusted" in interpersonal hostility dynamics. Another patient may find that his "blind spot" lies in the area of affectionate relationships, which he has a difficult time in perceiving correctly.

In addition to the above scores, some groups analyze the material for a so-called "choice score," which is simply the sum of the number of times that his name was mentioned in response to any question, regardless of its acceptance or rejection value. This score frequently points up the fact that some members, although not unanimously popular, have a strong emotional effect on almost everyone in the group, although the quality of the affect may be very ambivalent.

There is some danger that the sociometric assessment technique may have the opposite effect from what it is intended to have. This danger becomes acute when a therapist confuses the clinical purposes of the sociometric technique with the research purposes for which similar techniques were originally devised and used by Moreno and Jennings (1934). It is important for our purposes that the therapist forget his research training for the moment, that he does not force upon the group a controlled research project. Rather, it is essential for the group members to participate in as many ways as they possibly can to make the assessment meaningful to *them*, even though such assessment may not be meaningful to an expert sociometrist or social psychologist. In this way we frankly put our emphasis on the therapeutic value gained from learning to make participative use of the group.

Experience has taught us not to be naïve about the sociometric choices entered. In private sessions patients, particularly new patients, invariably communicate what they did not enter into the sociometric questionnaire and how they sometimes gave untrue statements in the questionnaire. In a group in which the percentage of relatively new members is fairly high, the discussion of withholding and defensive tendencies come up; their very presence naturally devaluates the reliance that patients can put

into the assessment result from the point of view of "reality training." Only the perceptions of advanced members are then taken seriously from that standpoint.

When we study more closely the type of defensive distortions that patients will enter on their sociometric questionnaires, we notice that distortions are made in the direction of whatever interpersonal effect was required at the time vis-à-vis the contact operations toward other members. For example, new members will be more honest and more perceptive with respect to those other members in the group with whom they have a quasi-stable relationship, either very close or quite distant. Distortions and downright lying will build up in choices involving members with whom the relationship at the time of the choice is in a state of flux or conflict. These experiences suggest great caution in the use of sociometric data, as they may not represent a realistic mirror of the actual interpersonal dynamics existent in a group.

Groups are conservative in the use of assessment. It is sensed as a clinical technique which reinforces the work, rather than the play or social mood of the group. Intensive groups vary greatly as to how often they will make use of assessment. Work-minded groups tend to have group assessments after about every twenty-fifth to thirtieth meeting. The therapist is, of course, alert to intensive anxieties which may be aroused in any specific patient by the assessment procedure. He would, whenever possible, give the patient an opportunity to discuss and work through these anxieties in subsequent sessions or in supplementary individual meetings. The latter functions as a "safety-valve."

### Boundary Awareness (Theme 11)

Boundary awareness refers to the therapy groups' discussions of the relation of the in-group to the external environment. Theme 11 occurred in the sample groups I and II twelve and eighteen times, respectively, in one hundred consecutive sample meetings. Psychotherapy groups stand in stark contrast to groups organized to withstand strong hostile external pressures. An example of such groups are those reported by Homans (1950)



in his studies of interpersonal relationships on small military ships during World War II. Homans showed that the inner system of a small group, particularly leadership dynamics, depends on the nature of the external pressures on the group from the larger environment. In studying the dynamics of the leadership of the psychotherapist in a therapy group, one must be aware of the type of external pressures that may be put upon the therapy group from the outside such as an attitude against group therapy on the part of the patient's family. Even when the existence of a therapy group is not (realistically) threatened by any organized counterpressures, members of such groups nevertheless maintain a boundary vigilance as if external threats to the group do in fact exist.

The more cohesive a therapy group is, which is roughly indexed by the length of participation of the majority of the members, the more actively members concern themselves with the boundary problems of the group. In less cohesive groups the concern with the boundary processes is repressed, and the concern is delegated to the leader, who is charged by noncohesive groups to "handle" the group's boundary. Such clinical procedures traditionally assumed by the psychotherapist as selection of patients, termination of patients, the use of observers, second therapist, and professional visitors, are all of concern to the group. In fact, they are the group's business, not just the leader's.

The various processes by which this principle finds expression can be demonstrated in various phases, the most instructive being the process by which the group participates in the selection of new members, which has already been described in previous chapters. In the natural concern of any therapy group which is not "run" by clinical authority, and which thus does not, as groups often will, give up concern for its boundary, the leader role is that of a gatekeeper, as described by Kurt Lewin (1947). But the gatekeeper's role, which governs the inflow of new members and the outflow of graduating members, is continuously regulated and sanctioned by the group.

To observers familiar with the usual groups which leaves boundary problems to leaders, membership committees, and the



like, the strong emotional concern of the cohesive therapy group with such problems is at first surprising. Closer study, such as that conducted by Bion (1948-51) leads to a confirmation of the fact that a group-centered, cohesive membership is genuinely concerned with and can quickly learn how to manage its own boundary affairs intelligently.

## Chapter 12

### OBSERVATIONS OF THERAPEUTIC GROWTH PROCESSES

---

Symptoms, emergency situations, dreams, drawings, role playing and participation in group management, the various activities and themes so far discussed, are only the background of the therapeutic process, which itself is of primary interest to both patient and group therapist. Throughout these various group activities which make up the obviously observable, the self-evident proceedings of the patients gathered for the purpose of psychological rehabilitation, this purpose is forgotten only for brief periods of resistance, defense, and escape by the patient. No one, whether emotionally disturbed or otherwise, will regularly spend a good part of his leisure time and of his monthly income on anything that is not believed to be in the personal interest of the individual. How is the belief that participation in intensive group psychotherapy will help the individual to grow toward a more constructive and a more enjoyable life sustained over the many months and even years of treatment?

In order to answer this question we have found it expedient to make use of the term *theragnosis*. Theragnosis refers to a variety of communications which aim, by the conscious purpose of those participating in the communications, (1) to diagnose an individual's personal idiosyncrasies in interpersonal contact and traffic; and (2) therapeutically to help the individual patient to a better understanding of how his repeatedly observable behavior patterns affect others in the therapy group. Theragnosis refers to a combining of diagnostic and therapeutic functions. Such a combination is characteristic for most activities in any intensive group therapy program.

Any amateur sportsman or woman who has played at darts or golf or tennis knows that there is a great difference between the intended and the obtained result. The intended result is, of course, to make the ideal hit, the obtained result is usually unintentional. It accrues from factors beyond the conscious control of the striving individual, resulting from "unconscious" factors.

This holds true also of group therapy participation. The patients fully intend to "go for" the ultimate gain: self development. They consciously strive for self-growth, they want to be cured and to live a more constructive and happier life. The professional therapist consciously wants to help them in this aim. While this conscious aim is constantly harrassed and diverted by forces reflecting the paradoxical resistance of patients against the very process of rehabilitation which they seek (cf. Mowrer, 1952), there is, nevertheless, a steady direction of the patient's interest in self-development through participation in group therapy. In this chapter we shall deal with those phases of group therapy life which are devoted directly and self-evidently to the fulfillment of each patient's manifest wish to be cured of his emotional difficulties and conflicts.

While much of the discussion of the therapeutic process is left to later chapters, the discussion in this chapter of themes 14, 15, and 16, the "clinical work activities," will give the reader a short preview of some of the fundamental aspects of group psychotherapeutic processes.

### "Going Around" (Theme 14)

This theme refers to a process of communication by which every member in the group gives an uncensored expression of how he himself is affected by and how he perceives other members in the group. In beginning groups the going around type of communication is mainly restricted to a ritual which is used as a warm-up technique. The going around ritual consists of having each member speculate freely about the emotional effects that the next member in the seating arrangement has on him. Group I felt this to be the most effective warm-up technique in getting the communication away from intellectual types of interpretive

discussions and toward free associative, speculative reactions on an emotional level.

The field owes to Alexander Wolf a clarification of the therapist's role in the going around process. Wolf (1949-50) places "the expression of spontaneous uncensored speculation about other members of the group" in the third of his six stages of treatment. Wolf describes this type of free association about one another as coming in the development of the therapeutic process after free associations in which dreams and reveries are the main foci of interest.

We structure and explain the going around in its ritualized form as one of the warm-up techniques available to groups to start the session. This seems to facilitate the group's eventual growth into a phase where it can make use of going around in a more spontaneous manner. Through an early introduction of the going around method, patients very early recognize that they are to participate in the role of the therapist, and that their function in the group includes not to repress, but on the contrary, to be alert perceptually to any trend in the quality of emotional experience which any given member may produce. Wolf points out that all "patients are asked to become analysts." Wolf recognizes the "utmost therapeutic benefit" which patients derive from rewarding experiences in connection with having made spontaneously and unpremeditatively accurate identifications of other patients' motives, patterns of behavior, or attitudes. In both our own and Wolf's group therapy management the patients are encouraged to express the experience that a suggestion made by other patients "rings a bell," or is a "touché." In this way the neurotic insecurity about not having anything to contribute to others is counteracted.

### **Analyzing Other-Self (Theme 15) and Self-Other (Theme 16) Effects**

These two themes are the most "clinical" type of interpersonal communication. In content and form they are similar to the previous theme of "going around," except that they occur spontaneously in all sessions of established groups, not just as an occa-



sional warm-up technique. The essence of the "analyzing" process is speculation. Every patient verbalizes how he feels the effects of others on the self and vice versa. Patients likewise attempt to label the motivational reasons for these effects. Also included in these themes are acknowledgment and/or resistance responses to these speculations of the self.

The speculative communications are followed by self-discrimination and self-integration communications (Theme 16). When a patient speculates or attempts to label interpersonal effects, or unconscious motive, he tries to recognize *what within himself* made him such a keen or special observer of such and such processes in others. The reader is already familiar with this type of self-discrimination communication as a sequelae to advice giving (cf. Chapter 8).

The self-discrimination processes are not instigated only by speculation concerning the effects of others; they frequently are stimulated by defensive needs, as when the patient is the target of speculations by the majority of the group. The situation often arises by which a majority of the group forms a consensus of opinion and tries to show a patient the nature of a particular behavior pattern more fully. Since these patterns invariably have the dynamic significance of ego defenses, the "diagnosis" and confrontation by the group is at first experienced as a threat. But when group belonging and cohesiveness is high, the patient eventually accepts the group's theragnostic work and overcomes his resistance. Thus, the group dynamic factor of pressure toward conformity (cf. Chapter 17) has, in group therapy, the clinical significance of helping patients overcome ego-defensive resistances. The patient must wrestle with the majority effort to demonstrate to him the nature, as well as the underlying need for his defenses. This is a very potent motivation for self-discrimination and integrative insights.

This theragnostic work by the group is of singular therapeutic significance, for through it the patient has the chance to see "the back of his head," to sense the nature of his psychological problems. Thus, the stage for making personality changes is at last laid. Knowledge of his own inner neurotic "enemies" is possible, in spite of a neurotically weak ego, because *the group shares the*

*threatening insights*; in fact, it was the group which "produced" the insights first.

An additional factor to group conformity (or identification with the group ego) which makes it easier for the individual ego to accept that kind of insight into neurotic mechanisms, which would be too threatening in intensive individual therapy without very prolonged and expensive treatment, is the reciprocal nature of the theragnostic process. The analysand is less resistive and defensive toward his analysts, since he himself functions in the role of co-therapist and contributes in the analyses and confrontation of neurotic mechanisms in others. He is not only the recipient of anxiety-evoking stimulation (by way of receiving interpretations and confrontations) as in all other types of "insight therapies," but he is also the active instigator of such stimulation. The theragnostic themes 15 and 16 have a "give and take" quality in which "fair play" demands of each participant not only to "dish it out" but also to give the others the same privilege toward him.

It is impossible to provide the reader with a protocol of the type of communications which occur under themes 15 and 16. This difficulty is due to the fact that these theragnostic themes take a long time and are usually carried on in piecemeal over a large number of group therapy meetings. It may take a group as long as a year and a half to work on, say the theme of patient L-M's resistance to saying "touché" or acknowledging the group majority's perception of him as always trying to defend himself against an irrational threat from the more attractive, usually hysterical women in the group. Furthermore, this type of theme comes up, not in a continuous way, but as a by-product of discussions on many topics, and to all other themes. It is mentioned here and there, and wherever any of the more advanced and insightful patients or the therapist can see another instance of a defense pattern in action. The therapy group's "theragnostic," analytic work begins at the moment a patient expresses a dream association or some feeling about another member. Our description of the group's analytical work uses the "phase" concept.

The practice of group psychotherapy is a situation in which the observer can compare simultaneous or near simultaneous

changes in different individuals. This observation is facilitated by the presence of differentiating cues. It is easier to observe a phase in an individual patient who is undergoing a different phase. For example, more advanced patients recognize and will communicate their recognition that they have already passed a phase which the newcomers are just then experiencing. This differentiation by the self mediates ego-enhancing perception of progress on the part of the "older" group members, which is further strengthened by the experience on the part of the older members of being able to help the newcomers. It is also possible to recognize simultaneous or closely related changes in several patients at the same time. The group therapist can notice that patients progress in a fairly orderly manner, and that they do not show behavior characteristic for different phases in random fashion.

Viewing the therapeutic process in terms of phases has been suggested by many authors. Writing on the basis of clinical observations made in the practice of individual psychotherapy, Charlotte Bühler (1952a) suggested five phases of the maturation process as follows:

. . . first, an *anxiety* overwhelming the individual by the impact of a stimulation; second, a *recuperation* from the anxiety; third, the development of the *need* to know and to control the dangerous object; fourth, the *adaptation* to it; fifth, the *constructive use* of the mastered material by means of which the individual *expands* his realm of life.<sup>1</sup>

For the purpose of pinpointing the major aspects of the therapeutic process of the group, Bühler's economic scheme of five phases must be expanded. The observation of relatively distinct phases of therapeutic growth is facilitated in the group practice.

### Seven Phases of the Group's Theragnostic Work

The member-member exchange of speculations and analyses of self-other effects, which advanced groups, with the active help of the therapist, are capable of, is a continuous process which can be best described in terms of steps or phases.

<sup>1</sup> Quoted with permission of the author.



**Phase 1: Sensing a Behavior Problem.** Any behavior manifestation *tangential* to the stream of group on goings is perceived by group consensus as a "peculiarity" of behavior. Because of the group's anxiety concerning nonconformity, group majorities are keenly motivated to understand nonconforming, idiosyncratic behavior. This leads, first, to the establishment and demonstration that a "peculiar" pattern of behavior exists. Such a demonstration involves either a "serial analysis," that is, reference to repetitions of the pattern over a relatively long time span, or a "typical cue" analysis, that is, relating a "peculiar" behavior manifestation to the existence of a cue-stimulus situation existing in the group (as the arrival of a newcomer). This in turn leads to the recognition of a *conflict*.

**Phase 2: Acknowledgment of the Behavior Problem and Conflict.** After group consensus (or group-sanctioned leader interpretation) has established a diagnosis of the adjustment problem, no further analytic work, beyond recognizing the esoteric pattern again and again, is done by the group until the patient, in whom the adjustment problem is seen, can say "touché" or acknowledge his full awareness of it.

**Phase 3: Reactive Avoidance or Suppression of the Recognized Behavior Problem.** Acknowledgment of the problem often leads immediately to a counterphobic avoidance or suppression of the diagnosed behavior problem. New group members will reinforce this tendency of the subject: "There you go, doing it again," may sound the spontaneous warning. The patient in question is quite willing to change. Some can and do change on this counterphobic basis alone. Many patients will thus rid themselves without further deeper analysis of many disjunctive interpersonal behavior tendencies which have made their interdependent living with others so difficult. But just as often, some behavior problems remain persistently manifest; any "change" is sensed as "a front" or "phoney" by the group. Then the group and the patient involved give in to the stubborn persistence of the repetition compulsion and try their hands at the next step.

**Phase 4: Pinning Down the Instigation for the Behavior Problem.** Now the group turns its attention to the specific na-



ture of the conflicts evoking a certain emotional quality from the diagnosed behavior pattern. To the therapist and to the more insightful patients, this seems to have a relationship to the form of the patient's group participation. Something like this may be said: "Whenever you (P) are without Y and Z, *then* you show behavior pattern X," or "Now tonight you *must* show your behavior pattern X, because you are threatened by the persons and events you just observed," or "Always and only when A is upset do you (P) get upset." Again the "touché" is sought by the group. It may take a long time to come, and after acknowledgment, the patient may again at this point use the counterphobic change. But after establishment of a social stimulus-response relationship, and after the "pushing" by the group toward the counterphobic change did not succeed, certain of these stimulus-response patterns doggedly remain. Their irrationality is now crystal clear, not only to the group, but also to the manifestant, the individual involved. The group may take a long time to acknowledge "defeat," but eventually they venture, with the help of "projective behavior analysis," into Phase 5.

**Phase 5: Recognition of Unconscious Needs.** By this time the previous four steps have yielded considerable perceptive material, not only on the quality of behavior patterns, but also on the quality of instigating conditions which evoke behavior peculiarities in and out of the group. Now it will be relatively easy for the group to speculate concerning the nature of unconscious needs which are "answered" (by way of defense) through the peculiar behavior reactions. Invariably the unconscious need is in the form of protection against a threat, for example, to masculinity or femininity, or to some other aspect of ego security and adequacy in general. Now, with group consensus of the recognition, which goes as "deep" and as historical as the patient's projective responses allow, there is again the group's pressure for acknowledgment. And after receiving the "touché," there appears a further step.

**Phase 6: Demonstration of the Unreality of Defensive Needs.** The recognition of unconscious threats leads to an examination by the group, and eventually by the patient, of their

lack of necessity for maintenance—of their truly illusionary nature. This takes the form of demonstrating the projective, transference or set-up nature of the *invented* threat. More often than not the method of creating a threat is very ingenious on the part of intelligent patients. They often entice behavior in others which in turn justifies their feeling of the existence of a threat (the set-up operation). Once the group consensus is reached on the illusionary nature, the lack of realistic necessity for a threat, and after the patient in question really sees this too, as for example, feeling continuously rejected by the actually accepting therapist, again the counterphobic “cure” is attempted, and often successfully. But again, some patterns may persist until the seventh and final step is attempted.

#### **Phase 7: Discovery of Ways of Utilizing the Environment.**

Patients who have gained sufficient ego strength in therapy are capable of taking an even more fundamental step, which goes beyond control, selective living, reaction formation, and the removal of unconscious blind spots mentioned above. These patients are not satisfied to terminate psychotherapy until they have really worked through, completed, and thus removed the ego's need for maintenance of the defensive, disjunctive patterns. In this last phase of the theragnostic process (discussed more fully in Chapter 14) the patient learns to live a pattern of life in which new energies are available to the ego. He begins to make the most constructive use of the potentialities for creative and satisfying living that can be realized within the limits provided by the culture and inherent in his personality structure. In this process both patient and group seek and find ways, conjunctive and constructive ways, for satisfying persistent, previously unconscious needs (that previously were thought of as unmanageable). Usually this takes the form of developing what Freud would have called “sublimated” outlets, through self-expressive creativity, and other activities. In this process the group succeeds in helping patients to give up trying to satisfy unconscious urges through the manipulation of other persons (set-up operations). They are encouraged to expand the response repertoire of the self.

## Oscillation Among Therapeutic Growth Phases

The complexity of the group's theragnostic work is understandable when it is realized that the various individual patients go through different growth phases while they interact with each other at any given time. This creates a complex impression. When one observes the therapy group as a whole, one can see mutually conflicting processes occurring simultaneously. For example, group therapy participation provides for ego-strengthening experiences, yet it produces strong anxiety. It is a slow moving, often painful and tension producing, clinical depth therapy, yet it mediates tension releases. There is the overcoming of feelings of isolation, allowing for immediate ego support, catharses, and social gratifications, yet there coexists the group's pressure toward deeper insight into unconscious motivations and conflicts.

Hull (1943), Fink (1953), and other systematic observers consider behavior oscillation as a basic behavior mechanism in adaptivity. The oscillatory character of the therapeutic progress of the group has been noted by Baruch and Miller (1949). Successful psychotherapy mediates ego development and growth. Ego development involves making rather fundamental changes in behavior and thought patterns.

The seven phases outlined above do not follow a smooth line of progress, but show significant oscillation. Progressive and retrogressive spurts can be observed during the course of psychotherapy. By progression, we mean strengthening, by retrogression, deterioration or weakening of the ego. The peaks in this oscillation process are of utmost clinical significance. Progressive peaks in therapeutic ego development, attended as they are by feelings of euphoria and pseudo ego strength, may result in a premature "graduation" from the long course of psychotherapy without standing the test of regressive oscillation, which usually follows progressive achievement. Retrogressive dips in the therapeutic growth curve show themselves in exacerbation of symptoms and suffering, and in the loss of defenses beyond the ego's integrative ability. Only when euphoric ego feelings with-



stand such a test is the likelihood of neurotic relapse reduced. Clinically, the regressive peaks are danger signs of the patient's having reached his threshold for absorbing threats and tensions, for the psychotherapeutic growth process is for the patient inherently painful.

### A Hypothesis Concerning the Nature of Resistance

One can liken these pains to "growing pains" which fluctuate in intensity, depending upon the phase of the maturation process undergone by the patient at the time. Anxiety is experienced whenever the patient's old equilibrium, his own system and structure of doing, believing and wanting things is disturbed by an outside agent who puts pressure on the entrenched ego system to change. The "pain" is an expression of the insecurity that comes from shifting the old ground from under the patient's feet. However immature his previous life strivings, however neurotic and unconstructive his old ego defense system may have been, it was his own. In fact, the old ground was *he*. Now this person is changing to new grounds, the texture, extent, and firmness of which feel yet uncertain. While within the orbit, however narrow, of the previous organization of the ego, the patient felt a certain freedom of movement. Now, in the new, relatively unstructured territory, he cannot as yet predict what might happen to him. The patient may then undergo retrogressive moments in which he actually feels *less* freedom of movement.

Even when the last phase is reached, the acceptance of realistic sources of satisfaction, a "last resistance," is due to a feeling of loss or disappointment and depression over having given up long accustomed neurotic satisfactions. Regression and resistance may occur at this point, as it does at any other time when patients have made a shift of response (from phase to phase). Resistance can be viewed as a reaction to therapeutic progress in the sense that therapeutic progress phases are interspersed with resistance phases.

Every psychotherapist has observed the seemingly paradoxical need of the patient to resist progress (Mowrer, 1950a). Resistance seems to be a necessary by-product of therapeutic



progress. *Without resistance there can be no progress.* . Periods of resistance are plateaus in the therapeutic growth curve which the ego requires in order to integrate newly-made discoveries. There is a protective pause against further unbalancing the organismic equilibrium at that time. Discovery is always accompanied by defense, and this defense is stubbornly maintained until all parts of the organism's ego system, both new and old, have reshuffled themselves into a new gestalt and order. Then, when a new equilibrium is restored, the system can again tolerate further change. Meanwhile, there is resistance against change. We can now expect that when the new discoveries upset the original ego organization too much and too suddenly, the resistance will be of a desperately intensive order. The psychotic patient's protection from being exposed to further pressure to change, to absorb new experiences, is an extreme example of resistance against growth. As is well known to experienced psychotherapists, insight into and discovery of new ego features can be therapeutic only if and when they can be integrated and absorbed into the existing ego structure. What is true of insight, that is, perceptual experiences, also holds for affect experiences, perhaps more so. A more systematic discussion of the dynamics of resistance will be found in Chapter 17 of this volume.

## Chapter 13

### OVERT ASPECTS OF THE THERAPIST'S ROLE

---

While the therapist's role is adaptive to the various activities and group atmospheres, the professional clinician has, nevertheless, a steady set of attitudes and criteria by which he guides his own conduct throughout *all* clinical procedures. When several group therapists follow the same approach, say group psychoanalysis, their personal characteristics and the idiosyncrasies of their interpretive or technical habits have been observed to have a great influence. Therapy groups with different group therapists create very different group atmospheres, even though they presumably function under the same theoretical orientation, according to Powdermaker and Frank (1953).

It has been the author's experience as a postgraduate teacher and supervisor of psychotherapists in training, that sooner or later, every responsible group therapist develops his own concept of the roles he actually performs in his groups. He also develops a level of aspiration concerning the "ideal role" he is striving for in his professional growth. The eighteen *do's* and the nine *don't's* given below are a part of the author's own set of professional values by which he attempts to be guided in his daily group therapy work.

#### The Do's

1. *Do* try on the deepest emotional level to be an accurate reflector of the experiences of the patients. In trying to improve your clinical skill with respect to functioning as a feed-back mechanism, locate your own perceptual sensitivities and dense spots, just as you are trying to locate them in the other patients.

Discount the naïve belief that anyone can or does ever accurately reflect the full range and quality of another's emotional experience.

2. *Do* remember that you are a service-rendering member, not a parasitic, "scientific observer" of the group.

3. *Do* think of a group of patients as a basically constructive force, a manifestation of the capacity for mutual aid in man, which can and will show.

4. *Do* recognize your responsibility for expert clinical leadership, for the therapist is both promise and threat to the effective functioning of the group.

5. *Do* contribute to the group, through your clinical helpfulness and democratic leadership, rather than through "lecturing," all that you scientifically understand as being helpful to the group's self-regulating and self-growing potentials.

6. *Do* share what you can of your knowledge and also of your personal feelings, experiences, and values with the group, when such sharing can serve a useful stimulus.

7. *Do* help patients in the group to increase their tolerance for individual differences, which has impressed you so much in your scientific training in the social sciences.

8. *Do* always attempt to gauge correctly and reflect the majority group consensus concerning any topic. A consensus is always present, often in a covert, subtle form, with regard to anything that goes on in the group.

9. *Do* learn to distinguish among the group pressures on individuals, between those which represent manifestation of social reality and those which result from the group's fear of group tension, or those which represent a wish of the group to escape the work group and engage in play and catharsis.

10. *Do* acknowledge being puzzled. Remain curious and investigatory. Try to channel your problem-solving motivations along scientific and objective, rather than along "faith" and doctrinaire "school" lines. Examine professional information and seek professional consultation in whatever quarter you may obtain it, be it in the more general social sciences of anthropology, sociology, and social psychology, or in the clinical disciplines of medicine, psychiatry, clinical psychology, and social work.

11. *Do* always keep in mind that the goal of psychotherapy is the well-being of each individual patient. Often an individual patient's inner needs will make him behave in ways which make trouble and create tensions in the group. But through his "externalization," which is suffered by the group, the individual patient has a chance to undergo catharsis and later gain insight.

12. *Do* at all times reflect and reinforce the group's own natural, but usually latent interest in becoming aware of all the psychological elements in which it is involved. This will help them to find, with your assistance, realistic ways of mastering antigrowth forces within the group.

13. *Do* learn to see and respect the constructive wisdom of the unconscious which manifests itself in the spontaneous, unlearned evaluations of ongoing psychological processes by the technically "ignorant" patients. This attitude of respect for the patients' interpretative contributions does not derive from, although it is in harmony with, ethical values of reciprocal, democratic interpersonal relationships. It is based on the contemporary evaluation of unconscious forces as being essentially pro-learning (Miller, 1951), pro-reality (Fromm, 1951) and *not* necessarily anti-ego, anti-social reality.

14. *Do* accept your role as a guardian of a therapeutically beneficial milieu in which the suppressed and unconscious creative as well as noncreative impulses of the patients can find explicit shared communications.

15. *Do* clearly formulate the therapeutic objectives you wish to attain and the means by which they may be accomplished. Different group methods are suitable for different objectives. If the objective is simply to communicate expert information to patients, you would not think of employing intensive psychotherapy methods. When your objective is to provide support for the patient during a particularly difficult period in his changing course of life, you would maintain a limited program, creating opportunities for catharsis. You would try to offset feelings of isolation by encouraging exchange and sharing of frustrating experiences. You may then, with such a short-range objective in mind, help to strengthen ego defenses, such as displacement, intelligent use of authoritative guidance, and the



like. In contrast, if the mental and psychosomatic condition of the patient requires fundamental changes in his inner and his interpersonal adjustment, you will then use intensive, self-analytical therapy as an effective path for his rehabilitation.

16. *Do*, even though personality structure information is frequently unreliable, continue to try for better pre-therapeutic screening, diagnosis, and prognosis of every patient in apparent need of intensive psychotherapy. Proper grouping and selection involves more information than clinical hunches and impressions, even if you or your referring colleagues have excellent clinical intuitions, for mistakes in selection and group placement affect several other patients, and once made, they are very difficult to undo. Like cement poured into the wrong mold, any patient once accepted into a group usually settles there, even when both he and the group sense that his "fit" is precarious.

17. *Do*, in your selection procedures, recognize the principles of the social interdependence of human personalities. Do not select the patients' personalities in isolation, but keep in mind for what group constellation you are selecting whom. In this complex process, the feelings, intuitions and perceptions of both the group and the new member should, in addition to your expert clinical information, always become explicit and a guiding point in fulfilling your professional responsibilities to both group and individual.

18. *Do* engage in research. Keep records. Exchange your findings with those of colleagues. Try new ways, suitable to your personality. Have others look at them; they may be generally useful. Help the theoreticians out by making your findings, your explanations, and your new questions very explicit, so that they may turn the searchlights of their research facilities and experimental methodology on problems of vital concern to the serving practitioners and to the suffering patients.

### The Don't's

1. *Do not* underestimate your own unconscious drives and motives which, without clear recognition, may be aroused by the powerful stimulation of the group and will spoil your poten-

tial therapeutic effectiveness. Self-knowledge and mental health are still the first steps in psychotherapeutic leadership. Freedom from compulsive countertransference and neurotic dovetailing techniques are signs of good mental health in your successful patients. Are you equally free from these?

2. *Do not* behave "spontaneously" in a therapy group as you would in an ordinary social discussion group. Never act in a group unless you understand quite well your own motive as well as the clinical effects of your behavior on the group.

3. *Do not* encourage or reinforce the patients' natural tendency to cure themselves by and through authority; do not mislead them by allowing them to imitate *your* way of life and thought; do not exhibit yourself before an appreciative "audience."

4. *Do not* lend your hand to new groups' attempts to reject pathology and to demand conformity in terms of "normality." Help new groups to develop a value system which fits the fact that most members are, to begin with, deviants, that is, violators of group norms.

5. *Do not* get discouraged by the complexity of the life of the psychotherapy group, and the variety and intensity of emotions that it may arouse in the patients and at times in yourself. Patience and good frustration and tension tolerance are personal prerequisites for your psychotherapy practice. They grow with clinical experience.

6. *Do not* let your concern with helping to create and maintain a minimal level of cohesiveness in the group trick you into overzealous tendencies to suppress or divert group-disruptive realities. These must be patiently and tolerantly worked through by the group.

7. *Do not* allow yourself to be pushed into the role of guardian of the communication-suppressing forces of the macrocommunity. It is up to each patient to find that societal segment in which his values harmonize with the whole. The reality of the psychotherapy group within the larger "real" community is created in order for him to find what the values are by which he can live happily. You are the guardian of the reality of the therapy group, but not of the broader community, except as a

representative of "reality testing" of psychopathological tendencies.

8. *Do not* forget the patients after completion of psychotherapy. You can learn a great deal from past perspectives—your own and that of your patients. Follow them up, at least for two or three years, as a routine aspect of your job. Include in your follow-ups your "drop-outs" and failures. Study them in retrospect.

9. *Do not* think you are or that you have to be a "father" to your adult-peer patients. The adult therapy group is a peer group. This means that everyone participates in that leadership role for which his background and skill, his temperament and his knowledge best qualify him. These qualifications emerge in the course of experience in the group. Depending upon the relationship between the constellation of the patient and the personality of the professional therapist, for example, it may well become evident that the clinician is less a therapeutically effective interpreter of dreams than someone else in the group. Some member, other than the official conductor often is the most sensitive perceiver of interpersonal pairing. Every therapist has blind spots vis-à-vis certain normal and realistic factors which would make him an unreliable interpreter of the reality of group dynamics. As the culture of the therapy group grows over several scores of meetings, the qualifications and the type of service that the therapist and each patient can contribute to a particular group life phase becomes self-evident.

10. *Do not* forget that, inevitably, you help your own psychological growth, that, in a sense, you are a patient in your own groups. If the process of conducting psychotherapy groups fails to have a maturing effect on you, the therapist (Grotjahn, 1950), then your efforts are bound to be worthless to your patients. The clinical practice of helping adult peer-groups to create and to maintain democratic-participative atmospheres contributes significantly to the psychological growth of the group therapist.





## PART II

---

### OUTLINE OF SOME THERAPEUTIC EFFECTS



## Chapter 14

### ANALYSIS OF CONTACT OPERATIONS

---

The theoretical springboard for our technique of theragnosis is Freud's concept of transference and countertransference (Freud, 1940). We consider that the best vehicle for self-understanding which the psychotherapist can offer to a patient is to involve that patient in a live bit of interpersonal contact and traffic with himself and with other patients, and then show to the patient the way he tends to navigate in that traffic. For this reason we cannot go along with the psychoanalytic practice of interpreting all interpersonal traffic in terms of historical reactivations. One of the reasons why intensive psychotherapy takes such a relatively long time (and the intensive group psychotherapy approach certainly does not represent a short-cut in terms of therapy hours, although it is economically easier for most patients) is that only through repeated contact experiences between therapist and patient, and between patient and other patients can enough data be accumulated to permit the recognition, reflection, and analysis of the wide range of typical patterns of contact operations of a given patient.

#### Transference as a Special Instance of Contact

The whole field of psychotherapy owes to Freud's pioneering genius, to his persistence and courage of believing in his own observations, the pouring of the foundation under our professional feet. We particularly recognize that without the tremendous amount of work that has been done by Freud and his followers in the clarification of the transference aspect of the therapist-patient relationship, our own search for progress would be impossible. But we also believe that Freud specifically, and the majority of

his psychoanalyst followers, whether classical or neoclassical, have generally failed fully to follow up and therapeutically to exploit the rich potentialities of the transference phenomenon.

Freud assigned to transference great theoretical importance. Yet Freud, probably for reasons of his "distant" and discriminating personality, failed to lead the way in showing how the tendency of the patient to demand of the therapist support for his projections can be clinically exploited for the fullest therapeutic benefit. Freud's preferential attention to the historical perspective in psychogenic and personality structure theory against detailed concerns with therapeutic efficiency left him satisfied that in his letting the analyst function primarily as a "screen" he had, for purposes of theoretical research, all Freud, the theorist, needed: a tool for the demonstration of the dynamics of the unconscious and the dynamics of hypothesized ego-id-superego relationships. Today, sixty years after Freud's groundbreaking, thanks to him and to psychoanalysis, we need no longer be so concerned with demonstrating the unconscious, and with fighting for a specific theoretical point. Everyone now accepts the discovery of unconscious motivations. Now let us take the discovery seriously.

Now we need to know how to exploit therapeutically, and how to apply the accumulated knowledge of unconscious mechanisms. Especially, we should make better clinical use of interpersonal contact dynamics than the transference concept permits. The psychoanalytic concepts of transference and countertransference, when seen in the broader frame of reference to include all contact operations between people, appears as a very special and restricted aspect of the whole range of unconscious determiners of interpersonal communication. The specificity of the transference phenomenon, when viewed against the wide range of possible interpersonal emotional exchanges between people, normal or pathological, mutually constructive or destructive, is clear. When, as in psychoanalysis, one sees all interpersonal relations in therapy in terms of this specific transference aspect, the full understanding of contact dynamics is made impossible.



Of supreme importance in the organism's motivational structure is here-and-now survival. The wish to revive, to re-experience the world of infantile relations can only be *one* specific and pathological aspect of the organism's goal structure. Freud postulated correctly that experience which was internalized may at some later time become externalized. Experimental studies of generalization by psychologists of learning have substantiated the possibility that a present contact operation may have the psychological significance of a compulsive repetition, an attempt at mastering a previously internalized interpersonal experience. This reactivation concept is, however, too limited and specific a concept to cover all important aspects of interpersonal or contact psychology. Experience with the group medium makes clear that, in the group, a greater variety of interpersonal dynamics will be demonstrated than was true in the individual therapy setting. Consequently, broader concepts of interpersonal communication, concepts which go beyond those which have fairly adequately described the most important aspects of individual therapy, must be developed. To encompass more of the variety of specific manifestations of interdependence observable in group therapy, a deeper understanding of the psychology of communication, contact, and interdependence is required.

### Beyond Transference

Various descriptive concepts of interpersonal dynamics have been developed since the original rapport. To the psychoanalytic concepts of transference, countertransference, and identification have been added by other observers of interpersonal processes such concepts as differentiation, social symbiosis, contagion, joining of power fields, coalition, self-other roles, disjunctive and conjunctive security operations, parataxes, and social atom. There is considerable contemporary interest in the careful study of communication and of group behavior.

In discussing our method of the clinical use of externalization, we shall avoid such terms as transference, countertransference, and "acting out," and instead use the more general terms of

*contact analyses, social field maintenance, and set-up operations.* Following a brief explanation of these concepts of our contact psychology, we shall present in this chapter the clinical technique of theragnosis, which is offered to implement the already available techniques of transference and countertransference analyses as they have been applied to the group medium by Bion (1948-51), Ezriel (1952), Foulkes (1948, 1951*a*), Powdermaker and Frank (1953), Schilder (1951), Slavson (1950*a*), Sutherland (1952), and Wolf (1949-50).

Psychosomatic sufferers and disordered personalities have lived "against themselves," against healthy biosocial principles for many years prior to finally accepting professional help to make some badly needed changes in their own thought and behavior patterns. To this task the professional psychotherapist not only brings his good will and professional devotion. He, in addition, has special human realizations and skills. His status as an "expert," a role defined by Sullivan (1951), is based on his continuous acquisition, through training, experience and research, of knowledge of those factors in human personality growth that will effect beneficial, as well as pathological changes in behavior.

Knowing some of these factors systematically, however, is not enough. He must further find practical ways of creating actual conditions in which factors theoretically known to affect people actually will affect them in a therapeutic situation. In this the practitioner often leaves behavior theory far behind, like the engineer who in solving practical problems of invention and construction has to solve creatively problems untouched by derivations from general theory (Conant, 1947). Psychotherapists understand and evaluate their own clinical art, their own personal procedures, against the background of scientific knowledge of the dynamics of interpersonal influence in general (Bach, 1952*b*). By this comparative method each psychotherapeutic practitioner can sense the ground on which he stands, evaluate what he is doing, and correct the rough spots in his own technique. A systematic background in the social psychology of interpersonal influence facilitates self-evaluation and improvement of therapeutic techniques, which to a considerable extent are idiosyncratic with each individual practitioner.

## Contact Psychology, Social Field, and Neurotic Distortion

The viewpoint of contact psychology focuses attention on the processes by which the inner anxiety and tension problems of the patient are aggravated or alleviated through effective or ineffective functioning in contact with others. Constitution, as well as the experiential history of the individual, determine the kinds of fantasy fixations. Contact psychology stresses the view that regardless of the degree of perversion, regression, or deviation of an individual's need tension system, no release or modification of the system can be accomplished without improving as quickly as possible the here-and-now contact operations of the patient. Research and clinical experience with the most mentally diseased patients—mute catatonic schizophrenics—has shown that they improve when and if a constant and accepted contact with a psychotherapist can be offered to the patient in such a way that he can utilize, practice, and gradually expand his limited means of responding even to such a favorable opportunity. Capacity for mutually gratifying interpersonal contact operations seems to be a very difficult goal for many individuals in our culture. Every clinician knows that, even in the case of mild neurosis, and one may say also in the case of the hypothetical normal human being, there is great room for improvement in interpersonal contacts.

Some psychotherapists have gone beyond our position and have made the improvement of social role, or communication skills, the basic goal and philosophy of psychotherapy. While we would lay more stress on individual ego-integration, Ruesch and Bateson's (1951) communication concept of neurosis is, nevertheless, in line with contact psychology.

The term "neurosis" refers to difficulties in the area of transmission of messages to others. All neurotic patients attempt to influence the behavior of others . . . without being concerned with the actual effects of their actions upon people; only the mature person is aware of the reciprocal effects of communicative actions and of the beneficial effects of successful human relations. The immature person is the principal bearer of psychosomatic manifestations. Unable to interrelate themselves as



mature people do, these patients still use the means of communication which prevailed in their early childhood . . . immature personalities tend to weigh unduly the information which they receive from their own body by means of proprioception, to the neglect of the information received from the outside world by means of exteroception. Hence they are unable to evaluate correctly the effect of their own actions upon others, and therefore they are unable to correct their information, in regard to a constantly changing environment. . . .<sup>1</sup>

The *theragnostic process* is one in which the patient has the opportunity to interact attentively with contemporaries. He is given a chance to correct his compulsive and ineffectual methods of communication by learning to recognize in the theragnostic process how his fixated response patterns interfere with efficient social field maintenance. Once a patient fully sees for himself the nature of his own contact problem, he will find more effective ways of maintaining a good place in the social field.

The contact psychological frame of reference does not claim to be a unified theory of neurosis and personality development. Rather, as Speer (1949) points out, the contact frame of reference owes its value exclusively to its pragmatic or tool function in the daily clinical work of the psychotherapist. In order to see the oral or anal fixations, therapists must put on the conceptual glasses of Freud. One does not see the longing for confluence in a bisexual organism unless one assumes the transference concept developed by Jung (1946). One does not see the wish of patients to reduce their fellow men and to gain neurotic power over them unless one thinks like Adler (1946). All unconscious mechanisms are "posits" only (Reichenbach, 1951). Any given posit may help to clarify the dynamics of one patient while obscuring the dynamics of another.

Concepts of contact pathology refer, on the other hand, to the here-and-now observable interpersonal relations of the patients. Contact psychology is the almost behavioristic study of interpersonal traffic, whatever the nature of the unconscious need structure may be, for it is the inefficiency of handling interpersonal traffic and communication which literally obscures the pa-

<sup>1</sup> Quoted from J. Ruesch & G. Bateson, *Communication: the social matrix of psychiatry*, by permission of W. W. Norton & Co., Inc.



tient's tension and need-reducing opportunities. In the close observation of contact pathology, the clinician, as well as the researcher, uses sieving concepts and definitions. We can define the contact frame of reference as "the study of that aspect of behavior which aims to seek, maintain, and defend interpersonal contact of a nature which through previous experience acquired secondary drive reduction value." We would, furthermore, postulate a *critical contact* for every specifiable inner need tension state. The critical contact would be the simplest, most economical, least conflicting contact operation for the reduction of a specific drive state. The phenomena of discriminating choice of sex, friendship, and business partners and associates can be adapted to the concept of the necessity for having such contacts actually critical contacts for the release of drive tension. The neurotic's repetitious attempts to impose indiscriminately upon any interpersonal contact drive-reducing functions that are alien to it exemplifies a lack of capacity to obtain satisfying critical contacts. This is manifested in the well-recognized phenomenon of a patient who wishes to maneuver the therapist into a position where he can have "transference experiences."

As we go further into the study of contact dynamics, we shall have to add concepts to which conditions other than drive reduction can be ordered. For example, under what conditions is a contact defended against interference from the outside? We probably will find that in order to answer a question such as this one, we shall have to develop the dimension of reciprocal versus nonreciprocal (one-way) contact. One can observe in group therapy that subgroups more easily give way to dissolving pressures from without when the relationships within the subgroups are of a one-way, rather than of a reciprocal nature.

We will have to go further when we come to questions concerning multicontact phenomena, for we can see in the group how certain tension releases require rather complex systems of simultaneous contact operations of three, four, or five or more individuals. The most simple and obvious manifestation of human interest in such multiple interplay is exemplified in the various team sports and games. Even more complicated examples are industrial, commercial, and political organizations.

Perhaps we are at the threshold of reaching for a better understanding of the psychology of "belonging" to groups. The researcher in group dynamics certainly has proved many times over the correctness of Kurt Lewin's (1948) postulation of "belongingness" as a basic item of psychological security and mental health. A more detailed study of multi-dimensional contact promises to lead us, beyond the discovery of strength of belonging, into what one might call a study of the dynamics of belonging. It now seems as though belonging can be reduced to the need to maintain a social field of contact. The passive implication of the word "belonging" often distracts from the active attempt of the person to build and maintain something to which he can belong. He builds a house in which he lives as often as he visits and feels welcome in another's house.

### Dynamics of Neurotic Contact

Contact is a necessary condition for biological and emotional tension reduction. But while the need for contact and the capacity to obtain it reside in the individual, opportunities for the right kind, or critical contacts at the right time with the right person, is a function of a variety of psychological forces, among which the personality of the participants is only one set of factors. These factors are modeled by Kurt Lewin's (1946) concept of "social field." The social field is at any given moment the totality of the here-and-now possible contact opportunities. The cognitive field is the way the person sees these opportunities. Psychotherapists and students of personality dynamics are interested in the process by which the individual patient makes it easy or difficult for himself and/or others to bring the possibilities of contact opportunities into actualization. Furthermore, the clinician is interested in the process by which each patient builds up or interferes with his own region of interpersonal traffic.

The neurotic person tends to gain interpersonal traffic by operations which Sullivan (1949) has termed "conjunctive or disjunctive security operations." One way in which neurotic patients make it hard for themselves and others to gain and maintain reciprocally tension-reducing, critical contact is through a

parataxic distortion in the cognitive field. Distorted perception of the social field is dangerous to the individual because it fails to furnish reliable information concerning the realistic possibilities and limits of the contact operations actually present in the social field. Neurotic patients have often been likened to persons starving in the midst of plenty, for they literally do not see what contact opportunities are potentially present in their social environment. Parallel to blindness there is the neurotic's well-known projective tendency to see negative, disjunctive factors in his social field which actually may be neutral or potentially benevolent.

Parataxic cognitive structure, however, covers only a small part of the neurotic's contact pathology. We have already noted in the previous chapter the factor of constitutional limit, both with regard to schizoid contact weakness and with regard to sex role. There are other factors, characterological idiosyncrasy for example, that determine not only how the field is seen, but how the person is seen by others, how he is sensed by others as a good, conjunctive, or as a bad, disjunctive, contact or agent of tension reduction. Every person, not just the neurotic, is interdependent with every other person in his social field. Mental health of the individual can be defined as effective management for all concerned in the interdependency of person with person in the same social field. The mental health of the society can be defined as the effective low-tension management of the interdependence of subgroups in the world society structure. This makes it clear that no one individual can be mentally or physically healthy, considered by himself.

The fact that psychological health or disorder is always a reciprocal affair between individual and social field has for a long time been emphasized by Burrow (1927). This consideration has often been stretched, for example by Greco (1950), into a supposedly valid argument against the improvement of the individual through psychotherapy or other individual growth-fostering methods. Greco's faulty argument is that neuroses and psychoses are natural and normal "expressions of conflicting group ties," that individual character and contact capacity, impulsive or controlled personality, have nothing to do with the



individual's tension level. His psychosomatic and/or personality disorder is said simply to "reflect" like a mirror the disordered group situation. The results of successful psychotherapy brand such extreme arguments as psychological anarchism, for the clinical practice of psychotherapy proves that the most effective way of changing a person's social field is to change the person into a more effective contact operator. For the human being, unlike any other animal, creates to a large degree the field of contact around him. Unlike the field idea in physics where a particle's movement may be fully determined by the field into which it is moved, the human being's social field is altered by his own entry into it. His entry into his own social field can effect a variation of quality and intensity with correspondingly significant or superficial changes in the constellation of the social field. Psychotherapy deals with helping patients (1) to make better, more discriminate use of existing conjunctive contact possibilities, and (2) to improve skill and capacity to build, maintain, mend, and defend a field of contact relation which by gradual experience has been found rewarding.

But there will always be vast individual differences in capacity to make constructive use of a material-political-economic paradise, and those who do not make too good use of it will always want to improve their individual way of life. In this sense the discipline and clinical practice of psychotherapy is independent of the political order. We must have the faith that natural, social, and political scientists try as hard to improve the molar condition of society as we psychotherapists are trying to improve in a molecular way the contact effectiveness of the individual. Often the failures of the natural and political scientists make the work of the psychotherapist difficult or impossible in many parts of the world. For example, in India the physical, economic, political, and religious conditions are so bad that it is almost impossible to try to "adjust" individuals. But often, too, the failure of psychotherapists to provide the proper guidance of a preventive nature to educators, parents, political legislative bodies, and leadership has made the work of the natural and political scientist harder.



So far psychologists and psychiatrists have failed to instill in the leaders and in the population sound criteria and principles of mental health, by which government, consumers, and workers could discriminate the psychopathic from the healthy influence, by which they could examine the mental health implications of their own decisions. The future looks brighter as the various specialists more deeply sense the interdependence, the unity of all science, not only from an epistemological, but also from an emotional standpoint.

In clinical work, we note the responsibility of the psychotherapist to help individual patients improve their effectiveness in contact management. What are the tools, the instruments at the disposal of the psychotherapist in fulfilling this task? To answer this question requires a study of the whole process of psychotherapy, the nature of which is still speculative. It is possible here to describe only those tools which the present author has found applicable for the benefit of his patients' growth.

### Principles of Theragnostic Technique

The vehicle of therapy is the give and take contact between the therapist and the patient. With the use of the group medium, the one-contact instrument is widened into a many-contact instrument. Furthermore, this many-contact instrument has a different quality from the one-contact instrument of individual therapy, as we have already noted. In the course of several years of experience we have developed a technique, an instrument which utilizes the therapeutic possibilities of the many-contact instrumentality of the group. We have called this method *theragnosis* to indicate that, while it is a diagnostic method of contact pathology (disjunctive contact), it is also therapeutic. Unlike the usual diagnostic method in psychotherapy, theragnosis is not "done" at the beginning of therapy, but rather emerges throughout the course of therapy. In order to describe the method of theragnosis, we need to effect some sort of order, however artificial, from the complexity of interpersonal traffic that occurs in therapy groups. If we want to utilize this traffic clinically, we

must first understand something about its nature. This leads us to the question of why people interact.

Regular attendance, strong emotional involvement, and lively interaction are the rule in properly managed therapy groups which have attained a certain phase of maturity. What are these group members so busy about? One theory in line with an ahistorical explanation of contact functions suggests itself: group members are busily engaging each other in *set-up operations*.

All experienced psychotherapists have a feeling for the variety of ways in which their patients attempt to involve them. The repetitively compulsive, disjunctive, and ineffectual quality of these involving attempts in fact constitutes the patient's neurotic problem. The description of a set-up operation model is an attempt to reduce the variety of neurotic involvement techniques to one simple form. Ruesch and Bateson (1951, p. 88) have suggested a communication model for the understanding of neurotic interpersonal operations. At one point they speak of the tendency of patients to "create a stage":

The condition which we commonly label "neurosis" is the result of unfortunate attempts of a patient to manipulate social situations with the purpose of *creating a stage* to convey messages to others more effectively. The messages are usually not understood by others, and the result is frustration for the patient. Then the patient is forced to develop ways of handling the frustration, which procedure further distorts the processes of communication. . . . By and large he tends to flood others with messages, in an attempt to coerce them into accepting roles they are not willing to assume. These compulsive attempts to shape situations and coerce people obviously result in unsatisfactory interaction. Neurotics, instead of correcting the messages which they transmit unsuccessfully, essentially repeat the same message over and over in the hope that eventually it will be understood. [*Italics mine.*] <sup>2</sup>

It is helpful for the therapist to pay very close attention to the processes by which his patients create and set up a stage; there are many ways by which one can describe this process.

Ruesch and Bateson's communication concept of neurosis, as well as the present contact psychological position, has been criti-

<sup>2</sup> Quoted from *ibid.*, p. 88, by permission of W. W. Norton & Co., Inc.

cized by some as "surface" approaches that do not clarify the "deeper" or "higher" emotional and mental processes. Actually, the study of contact has much to offer for the psychology of higher mental processes, or the psychology of the self, of thinking and of cognition. On the surface the nature of higher thought processes seems not to be illuminated by the study of contact operations. The study of concept formation, of the self, and of the world usually remains in the intradermal traditional frame of reference. Yet the dynamics of contact touch upon cognitive and thought processes in many ways as determining influences. In order to clarify the interrelatedness of contact psychology and traditional ego psychology, the condition of "no contact," or solitude, must be examined.

**Solitude.** Let us begin with the example noted by Murphy (1947) of the gifted, the creative, the inventive person, who by his very productivity becomes an isolated deviant. The psychological principles of contact operations apply immediately to him. A study of the contact operations of the lives of highly creative individuals reveals a curious vasillation between losing themselves in live contacts with peers and followers, and withdrawing into solitude. In solitude, integration and creative interpretation of the stimulations and the drive excitations and reductions experienced while in contact are achieved. Sometimes a relation seems detectable between the emotional quality of contact experiences of the creative person and the quality of the intellectual and/or artistic product produced in *solitude*. A more careful research attention to this type of relationship between dynamics of contact operations and dynamics of creative thinking promises to contribute to the clarification of the process of creativeness which is always of interest to psychologists (Guilford, 1950). The psychological meaning of creativeness is cued by its occurrence in solitude: *creativity is recuperation*.

The mental functions of sleep are by no means as obvious. They must be inferred. The first inference—that in sleep the psychological function is also recuperation or renaissance—expresses the principle of organismic unity of functions. Psyche and soma are two aspects of the same total organismic integration. But while the biochemical dynamics of physiological re-

cuperation can be studied by methods of the natural sciences, the dynamics of mental recuperation in solitude must be studied by the philosophical methods of imaginative conceptualizations in conjunction with clinical data-gathering, a method which, by the way, has been found very helpful in contemporary physics.

The group therapist has an excellent opportunity to make his contribution to the study of solitudinal functions. This opportunity is provided by the phenomenon that almost every patient undergoing group therapy makes use in his dreams of other group members and the therapist in the manifest content. Examples are provided in Chapter 9 where the therapeutic functions of dream reporting are discussed. Dreams mirror the quality of the contact life of the patient. Dreams usually do not reflect solitary situations or self-pictures. This is particularly interesting to contact psychology in view of the fact that the dreamer is physically out of contact and alone.

In the solitudinal night dreaming as well as in day dreaming the organism prepares himself for new and better contact operations, while at the same time going over, reliving, and integrating unfinished tensions from previous contacts. This dream work shows that not even in the physical solitude of sleep is the organism freed from his contact problems. A careful study of the correlation of dream content to the quality of the actual interpersonal operations and contact situation in and out of group therapy promises to throw more light on the preparatory and integrative functions of the ego in solitude. Therapy groups naturally engage in such analyses by relating dream contacts in which group members appear in the actual relationships the dreamer has in the group (cf. Chapter 9).

There are other lines of investigation that will prove useful in illuminating the contact nature of solitudinal activities. For example, the analyses of both process and product of highly original and individualistic creations in the arts and sciences will in all likelihood prove primarily to have meaning from the standpoint of contact psychology. It will probably be possible to discard dichotomous distinctions between "private" and socially shared thought processes, as solitudinal processes can be shown to have contact significance. Wolfgang Goethe, who spent more than



his share of time in creative solitude, and who was one of the most individualistic artists in the history of mankind, on many occasions gave expression to his recognition of the re-organizational and recuperative power of solitudinal creativity—an antidote to the excitations, challenges, pleasures and failures of actual interpersonal contact. It was Goethe who warned would-be poets and theoreticians that to be creatively imaginary, one has first to master the problems of realistic community living.

Another avenue is the careful psychological study of the effects of solitary confinement as a method of prison discipline. Usually the separation anxiety factor is stressed in this connection as an explanation of the effectiveness of this method of “calming” down rebellious prison deviants and troublemakers. Perhaps a more careful analysis might reveal that the “calming” is not effected by intensification of anticipatory fear (anxiety) over separation alone, but that in solitude the contact-sick inmate regroups his difficulties, reorganizes his cognitive structures so that upon re-entry into social contact he literally sees the world differently. In solitude he may have found a solution in which he can have faith, and to which he can give the “reality test” of new social contact.

It is in solitude that the individual recovers from old contact and prepares for new contact. This process seems analogous to map-making, and, as in the experience of Korzybski (1951), maps can be very misleading. The mental picture that the person makes of his figure position against the background of society may or may not be realistic. The therapist is a professional aide in the individual's map-making. The group, while not professional, is a very effective map-checker. Group consensus effectively evaluates the discrepancies which may exist between the individual's cognitive map of a social field, such as the therapy group, and the actual social reality, that is, the communications of sharable observations.

### The Self, Cognition, and Spontaneity

What place does the ego or self concept have in contact psychology? Relative to the intradermal personality reference

frame, it has a rather peripheral place. From the point of view of contact psychology, the self picture is a defense mechanism, a buffer system or relay station between contacts. The self concept is not a central integrative or even selective organ in the sense of controlling or directing contact. The ego interprets dead issues only, past experiences, and/or lapses in fantasies about the future. It does not direct the contemporary spontaneous life. Upon contact, the social instinct life (mutuality), rather than the self, governs unconsciously and spontaneously what a person will do with, to, or for another. The "self" has little to say about it. It can only concern itself with rationalizing post-mortems and fitting into some cognitive structure, in which the person can have faith, what actually did happen, or what is wished for, or anticipated in interpersonal intercourse. According to our view, cognitive structure determines only patterns of rationalizations, learned semantic structures about interpersonal contact. But the self does *not* centrally govern or control contact operations *in situ*.

The self picture is a mental construction which functions *ad hoc* and *a priori* (*pre hoc*) but not *in situ*. According to our contact psychological theory, persons in symbiotic contact or in defensive contact or any other type of contact, are taken over by unconscious forces which function spontaneously and which mediate the quick dove-tailing of the organism to presently available opportunities for drive reduction. Only monadic processes are influenced by the self (Sears, 1951a). Since interaction and contact involve diadic variables the "self's" control power is more than questionable.

Many psychotherapeutic practitioners consider it their professional task to help their patients to achieve rational control. Observations made in the daily practice of group therapy provide a very intensive antidote for two general assumptions: (1) that irrational in the sense of uncontrolled, undeliberate and spontaneous behavior is dangerous and destructive, and (2) that controlled, deliberate behavior necessarily produces more constructive interpersonal reactions. Over the years group therapy practice gives the impression that patients act more sensibly, more constructively, when their repressed mutuality is released

and when, in the rapid flux of interpersonal exchange, no time is had for anything but spontaneous "social reflex" action. On the basis of our experience, the position that the achievement of mental health depends on widening the horizon of cognitive awareness and control sounds like an incomplete stab in the dark, a groping suggestion, rather than a really explanatory concept of healthy conduct. It is true that much mental illness can be understood as an absence of integrative insight or a failure on the part of the ego cognitively to integrate and digest past experiences, but this concept has nothing to do with, or should have nothing to do with, the question of control of behavior *in situ* at the moment of interpersonal transaction.

It is our position that, except in rehearsed institutional situations where behavior is governed by culturally determined, stereotype role definitions, neither cognitive anticipation nor retrospective integration has a determining influence on interpersonal action. We consider such action entirely governed by automatic organismic mobilization. No one, healthy or unhealthy, ever has complete control at the moment, but the healthier person has a quicker rate of integration over just-past experience. The healthy person's ego-integrating mechanism is more efficient in adjusting to kinks and jolts. He is able to prepare his perceptual and communicative facilities more quickly for anticipated repetitions. The cortical learning capacity of the neurotic is probably less effective. Tolman (1949) has drawn our attention to the stripped map nature of perception in disturbed organisms.

In group therapy all patients fail to show the same acuity of perception of their own problems as they are capable of showing with respect to others' problems. We must distinguish between a person's mental adjustment to his own action, his happiness or unhappiness about himself, and the quality of his spontaneous actions. The fact that it is impossible to demonstrate in group therapy that individuals are governed in their behavior *in situ* by their cognitive self-concept emphasizes the need to differentiate between the psychology of higher mental processes and the psychology of spontaneous interpersonal behavior. Both are two aspects of organismic functioning. Psychotherapists have over-emphasized the cognitive insight learning aspect and have neg-



lected to study the function of thalamic processes in psychotherapy.

The view of the self as a buffer function in no way denies its importance in psychotherapy. Rogers' (1951) research into the formation of and changes in self-concepts during nondirective therapy has provided group therapists with a technique of observing under which conditions patients in interaction, *in situ*, "contradict" their self-pictures. Rogers' researches illuminate the process by which the self makes cognitive corrections for reality. These cognitive corrections of the self-picture are essentially defense processes through which the person mediates an organismic mobilization which assures integration and unity of the self-construction (cf. Hogan, 1952). Work on the self-picture is dear to Western man. For him it has the same psychological significance that "spiritual emancipation" for his unbearable reality has for the Hindu.

When the self-organization is viewed as an organismic defense mechanism against contact difficulties, the fixated, nonspontaneous nature of the doggedly repetitive, disjunctive, contact operations of the neurotic becomes understandable. A possible explanation for the dogged persistence of obviously irrational, nonconstructive, and disjunctive thought and behavior patterns is suggested by the idea of "organismic defense," by which is meant the tendency to mobilize the total organism around any contact which may instigate threat, anxiety, or a catastrophic reaction (Goldstein, 1939). Problematical contacts become the focal points, the reference points, for all other contact operations. This comes close to understanding the source of fixation of disjunctive contact operations, the type of process that Fairbairn (1952) conceptualized in terms of "introjection of bad objects."

An example is the place of the principles of *Karma* (past actions) and of *Tyaga* (renunciation) in the life of the average Hindu. The Hindu's life is filled with severe biological and psychological frustrations and pains. In order to keep the organism's unity, the Hindu's self-other picture, his cognitive structure, and his sense of values stress the same painfulness. Penance and suffering are elevated into boon through spiritual



emancipation. If the Hindu's way of life would reinforce and stress *Bhoga* (enjoyment), rather than condemn it as sinful, then the life of the masses of India would be psychologically unbearable. The Hindu religion, like all effective religions, and like some psychotherapy approaches, gears the spirit to the realistic frustrations of the world in such a way as to protect the organism's unity and facilitate the spiritual absorption and tolerance for more biosocial frustrations.

### Set-Up Operations and Technique of Theragnosis

Set-up operations can be exemplified in a multitude of ways that defy complete descriptions. The only communicative solution is to use exemplary models through which by the use of a few statements the common denominator of set-up operations can be designated. The set-up operation always involves several entities, that is, persons, say Alpha, Beta, and Gamma. Alpha is said to engage in a set-up when he consciously or unconsciously cues the others and arranges the surrounding field into a situation in which he can obtain an emotional experience or a drive reduction of a certain quality.

One can apply this model to a variety of examples. Convenient illustrations of set-up operations are provided by observations of advice giving in therapy groups. In observing who gives what advice to whom (see Chapter 8), one can note a statistically significant phenomenon: advice originates from an Alpha toward a Beta under the condition that Alpha perceives Beta's problem situation in such a way that his own problems are aroused, either on the conscious, or not infrequently on the unconscious level. No advice giving usually emerges from Alpha to Beta unless the latter's problem presentations touch upon the conscious or unconscious problems of Alpha. Thus, objective advice giving is nonexistent, except when it originates from a paid, professional therapist, in which case it is a very limited technique. Having noticed that a necessary, although insufficient condition, for the arousal of interest in giving advice is transitory conscious or unconscious identification, we can now examine which direction and quality the advice giving takes.

Alpha gives advice to Beta always in the direction that would solve a problem for himself. In other words, Alpha pushes the other or others into a solution which he himself, either wishes he could perform (in the case of unconscious problems), or that he has experienced as working in his case (conscious problem solving).

To come back to our set-up operation model, we note that advice giving fulfills the conditions of the model: Alpha attempts to involve others in behavior from which or through which by identification or otherwise Alpha experiences the emotion of mastery.

From a theragnostic standpoint, the fact that things do not go this smoothly is of considerable interest, and incidentally, reminds us again that the set-up operation is a symbolic model of contact operation and not a photographic description of contact reality. What usually goes wrong is that the set-up operation is unsuccessful, or at least not completely successful. Alpha may get the others to behave in certain ways, but the consciously or unconsciously desired emotional experience is not quite complete. This, in our opinion, is one of the explanations of hostility, anger, frustration and tension in interpersonal contact. It is, to paraphrase the unconscious Alpha: "I'm angry at you Betas and Gammas for not cooperating in my set-up operation, and for denying me the opportunity for the type of interpersonal emotional experience which I crave."

But even when the set-up operations work, they will portray to the keen observer their conjunctive or disjunctive (neurotic) character by the presence or absence, or rather by the degree of parataxic quality of emotional response. Thus, if a patient in group therapy seems to blossom into well-being and integrative functioning usually when, or only when, his set-up partners have been maneuvered into tears and depression, then surely the quality of the unconscious motivation is a neurotic need to castrate, to reduce, to squash and kill.

More frequently, however, the requirements of the set-up model remain unfulfilled. It is almost as if it were one of those models used in theoretical physics, which describe events that cannot possibly occur, regardless of what conditions are provided

for it. This is a fortunate event for the clinician, while it is rather unfortunate for the patient, momentarily at least. That is, the statistically general state of affairs is the aforementioned anger and frustration with the failure of the set-up participants to permit Alpha the fullest degree of emotional experience, and for which he, perhaps, entered the social situation in the first place. An example is the attitude of angry disappointment that millions of marital partners have toward each other. The marital frustrations derive from the closeness of the marital relationship as analyzed by Kurt Lewin (1948), rather than necessarily from a neurotic character structure in one or both of the pairing participants. Any close interdependent relationship is inductive, or should one say seductive, for attempting to fulfill as many need reductions as possible through this one contact with one partner. This would follow from the law of economy of energy expenditure. Consequently, absurd and grotesque set-up operations are, in marital life, attempted on each other; these can lead only to the angry disappointments already noted.

For the technique of theragnosis a complication arises from the difficulty in distinguishing between frustration and anger which represent a consummation or goal response, a successful completion, a fulfillment of a desired neurotic set-up operation (as in the case of depressive neurotics or negativistic schizophrenics) and frustration-induced instrumental anger as a function of the shortcomings of the dove-tailing behavior of set-up partners. In other words, feelings of pain, anger, and hostility, as in masochism, may be the goal of a neurotic set-up operation, while the same emotion may be an undesired effect of frustration. Here knowledge of temperament, constitution, and glimpses of neurotic character structure from projective test analyses are not only helpful but essential cues for differentiation. Fortunately, no confrontation of the patient by the group or the therapist concerning the possible demonstration of the quality of unconscious motivations underlying the set-up operation is made until there has been a repeated series of such patterns.

For the student of projective behavior and other psychoanalytic processes the above discussion suggests that set-up operations serve the same defense and mastery functions as do



projective displacement, repression and acting out. The set-up operation simply describes those conditions where defensive and mastery functions involve the dovetailing of other people.

### The Social Interests of Neurotic Patients

Experience accumulated since Freud's (1922*b*) brilliant understanding of the interpersonal pathology of jealous paranoia in the psychoanalysis of character disorders has led to a clearer recognition of the peculiarly biased types of interest in others by neurotics. The pathological nature of the interest has in many cases been related to specific fixations and "complexes." For example, Fenichel (1945, p. 510) describes various ways by which orally fixated patients

. . . try to influence the objects by force, by ingratiation, and by every magical means, not only directly to furnish the necessary supplies (as oral characters usually do) but also to behave in a special manner corresponding to the subject's ideal. . . .<sup>3</sup>

Similar idiosyncrasies of manifestations of neurotic needs in interpersonal behavior have been isolated by Graber (1931), who has described how compulsion neurotics engage in neurotic typing, how they consciously or unconsciously assign every person they are in contact with to some category of threat, which in turn determines the patient's reaction to the typed contact. The sexual phase of interpersonal relationships has been studied from the point of view of providing the stage for manifestations of neurotic needs. Genuineness of sexual satisfaction or pseudo or counterfeit sexuality have been given much psychoanalytic attention (cf. Fenichel, 1945, pp. 515 ff.; also Bergler, 1951).

While from a theoretical standpoint of personality dynamics the clearer recognition of those forms of defense and mastery, which involve the provocation of others to dovetailing reactions, is of minor theoretical value; from the point of view of therapeutic technique this particular type of defense is extraordinarily productive. Through set-up operations, we have, in addition to perceptual projections, dreams, and accidental slips of speech and

<sup>3</sup> Quoted from O. Fenichel, *The psychoanalytic theory of neurosis*, p. 510, by permission of W. W. Norton & Co., Inc.



hearing, now available another road to the understanding of unconscious motivation. The fortunate thing about this road is that it combines the possibility of insight with the possibility of change. It is truly diagnostic and therapeutic simultaneously. The confrontation and interpretation of motives and conflicts externalized through set-up operations occurs in the same situation and simultaneously with the occurrence of the externalization. This is unlike the dream or other projective behavior which occurs in situation X and is analyzed in situation Y.

In theragnosis the patient is literally caught "in the act" by his own behavior. Through the application of theragnosis and group therapy the patient has his neurosis in a fishbowl. Perhaps at first he himself cannot escape his neurotic patterns, but to the rest of the group they become rather crystal clear. Then gradually through identification with the group, the patient can accept with relatively little resistance the meaning of his patterns of set-up operations, and this spells the beginning for deep therapeutic effects. Now with the recognition of his inner enemy, of his neurotic patterns (which make satisfying relationships with the outside world difficult), the immense motivation of the human organism for problem solving begins to shift and applies itself to the relevant aspects of his life: his ineffectual contact operations and his pathological need structure. This should not be misunderstood to mean that therapy merely consists of learning more efficient social role taking. That is only a side effect. The point of concentration of intensive therapy is the modification of neurotic needs. The recognition of social ineffectualness provides the patient with the most reliable motivations to check modification of need structure. Group therapy experience can demonstrate to the patient that superficial social role changes do not necessarily effect inner conflict mastery and equilibrium.

### **Neurotic Touchiness and Sensitivity as a Theragnostic Tool**

A former student, Gene Barker (1947), provided some preliminary experimental basis for the belief that the method of theragnosis relies entirely on the condition of the neurosis or psychosis of the participants. Only neurotics and psychotics are

sensitive enough to see, feel, smell, or react to the type of contact behavior that we have attempted to illustrate by our set-up model. Furthermore, it stands to reason that more normally adjusted individuals would not be able to discover the material for theragnosis on the basis of the lack of interest and lack of need to maneuver people into neurotic behavior. At least this is my explanation of Barker's findings that when we try to keep a group of carefully psychiatrically selected well-adjusted individuals together in a therapy group arrangement, we failed miserably, while the control group of neurotics and prepsychotics, far from being satiated with the group as the normals were, resented discontinuation of the experiment, which was forced upon us by administrative university calendar accident.

The therapist must confess that he was very surprised at the results of these experiments in 1946-47, because, trained as he was in individual psychopathology, he expected that normal, socially adjusted individuals would be much happier together than would neurotics and psychotics with their supposed antisocial traits. Now he knows that the neurotic and psychotic is really not antisocial. He is just socially ineffectual, and to him in effect social situations carry a much stronger stimulus potential than they do for the more normal and self-sufficient individual, who more effectively maintains his social field of contact opportunities, while the abnormal still seeks it and tests it under the pressures of overwhelming intensity of need and incredibly primitive methods of gaining relief.

Professional psychotherapists know through their transference and countertransference analytic work that neurotic patients are very sensitive. This reaction sensitivity is manifested by a high acuity of perception of almost subliminal cues in social intercourse. Examples are the patients' alertness in sensing even the slightest manifestations of a nonaccepting or uninterested momentary mood in the countertransference of the therapist. These are not always verbalized directly to the therapist at the time of perception, but are revealed at a later date, or to other persons, such as co-members in therapy groups.

For those who live in close daily contact with a neurotic personality, neighbors, friends, marital, or business partners, work

team peers, this sensitivity has an inhibiting, "distancing" effect which gradually produces annoying or angry disjunctive reactions in the individuals in contact with the neurotic. The sensitive reaction to the slightest possibilities of experiencing disjunctive emotions (hostility, threat, etc.) is experienced as a nervous "touchiness" which makes it anxiety-evoking to be with or work with a neurotic. Gradually the neurotic is left alone, save for public contact operations governed by stereotyped role definitions, such as business transactions. Thus, the neurotic's opportunity for tension release through intimate and steady contact is further reduced, intensifying his inner conflicts and tension level. His already developed acuity for "evidence" of rejection, unpopularity, lack of a chance, injustice, or even aggressive hostility against him brings into focus increasing evidence against the world of his unloving and misunderstanding peers.

The circular and self-perpetuating nature of the neurotic's contact situation has obviously negative implications for the mental health of both the neurotic and those in close contact with him. There are, however, several niches in community life where the neurotic's sensitivity has positive implications. One of these niches is the therapy group. Here the negative value of neurotic touchiness turns into a positive value of sensitive diagnostic work.

But is not this perceptual sensitivity of neurotics to a large degree projective and parataxic? Is it not well known that the disordered personality sees only that which is relevant to his own subjective conscious and unconscious needs and conflicts? The answer to these two questions is a definite "Yes." Does the subjective-projective quality of the neurotic's perceptual acuity spoil its diagnostic value for "lack of objectivity?" Our answer to this question is "No." An affirmative answer would follow on logical grounds from our acknowledgment of the subjective-projective quality of neurotic perception (parataxis) were it not for the communication check and countercheck system which therapy groups provide as the background for any specific or single observation.

In the course of the theragnostic work of the group members, there emerges over the months a rather clear-cut pattern of para-



taxis peculiar to each of the older members, while in the newcomers the particular flavor and direction of their parataxes has not as yet emerged. Eventually every member acquires a perceptual acuity-speciality. The group may say: "Harry is our 'Geiger counter' for sex," by which they express their experience that Harry, a paranoid schizoid patient, has a knack for picking up *in others only* that phase of their unconscious life that tends to be externalized along homosexual and/or heterosexual set-up operations. Another patient may be recognized as the "guardian of democracy" because of her acute sensitivity regarding anyone's tendency to dominate, not just the group, which is usually obvious to all, but in subtle subgroup and pairing relations. A third patient may be recognized and used by the group as an expert detector of nonacceptance, rejection, and covert hostilities. Still another patient may contribute to the group his neurotic sensitivity concerning the development of closeness, affection, or love between two members, including the presence of latent signs of positive "transference" contact with the therapist. Still another patient, usually one whose style of life has been for decades a more or less bitter "being on the outside looking in," is the group's radar instrument for detecting the development of and changes with respect to subgrouping or cliquing within the group.

These patients are keenly aware of any discordant items underlying pairing. The therapist himself is naturally thought of as the expert perceiver of tendencies (in others) to dominate the group, or to destroy the group, or to violate its boundary. The therapist also is usually the most sensitive to the perception and diagnosis of group atmosphere and mood, especially group tensions due either to satiation with or inhibition of ongoing emotional contexts. Thus, the therapy group has been likened by Karl Bühler<sup>4</sup> to the model of "a group of seismographs," each instrument registering different aspects of interpersonal dynamics occurring in the group.

Objectivity of perception is gained by the comparative check and balance method possible in the group. This is a process of seismographic synthesis of the various human perceptual instru-

<sup>4</sup> Personal communication (1952).



ments. One of the leadership functions that the therapist must perform in letting this kaleidoscope manifest itself is, on the one hand, to provide freedom of functioning for the seismographs and, on the other, help the synthesis of the various impressions. For when the neurotic instruments, each slanted in observation to its own inner needs, do come to a synthesis or a near synthesis, that is, when in spite of a high degree of subjectivity, there is rather common agreement of all perceivers that a certain contact operation has such and such a latent quality, or such and such externalized effect, then it is up to the therapist to give closure, and to reinforce such common products of the group's combined theragnostic work. In this process the therapeutic potentiality lies in the opportunity for the object of the group's perception to study how he, the patient, affects the world. And in the case of his role as a special instrument, he has occasion to examine what within himself makes him so keen, so acutely aware of, such a reliable instrument for the detection of just such and such patterns. Thus, one form of externalization, what some may wish to call "perceptual acting out," serves a dual theragnostic function: it contributes frequently to the group's detection of the interpersonal effect of a given patient, and secondly, it regularly gives expression to the motivational areas to which the perceiver's organism is alerted and mobilized.

The present technique of theragnosis really combines the psychotherapeutic suggestions of the late Harry Stack Sullivan (1949) with the orientation proposed by the Tavistock Institute workers in group therapy: Bion, Ezriel, Sutherland, and others. Sullivan, always stressing the interdependence of personality, while coining the clever phrase, "the personal is always interpersonal," thought of personality as "the relatively enduring patterns of recurrent interpersonal relationships." Theragnosis is a technique by which the patient has an opportunity to become aware of and to get a real feel for these patterns. In England, Bion (1948-51) and Ezriel (1952) follow the "principle of adhering strictly to the here-and-now interpretations." This emphasis is similar to the theragnostic approach, and, furthermore, by not just emphasizing the individuality as the Sullivanian group seems to do, theragnosis is akin to the Tavistock approach, which

stresses the technique of "analyzing the role which each group member takes up" (Ezriel, 1950a). In his technique Ezriel thus theragnostically "demonstrates to each group member his particular defense mechanism in dealing with some unconscious tension of his." Bion's (1948-51) idea of having the therapist understand what he calls the "valency," that is, the personal mode of giving expression to a group emotion, is a theragnostic process by which the patient gets a feel for those conscious or unconscious need tensions which find satisfaction or frustration in multilinear contact, that is, in group situations. Wolf's (1949-50) idea of the less inhibiting nature of the group ego makes it possible to derive the proposition that the motives which are externalized in the group tend always to be closer to unconscious dynamics, and relatively free of repression. In other words, theragnosis utilizes both the neurotic sensitivity as well as the disinhibiting influence of the group atmosphere as instruments.

The simultaneous perception of idiosyncratic or "Sullivanian patterns" with insight into "Bionian valency" have therapeutic implications which go beyond the concept of expanded insight. They touch upon the therapeutic effects of the process of symbiotic participation in group emotions. These implications are discussed in Chapter 15.

These observations touch upon two points raised in connection with theragnosis: first, they clarify the natural but naïve objection that in group therapy "the blind lead the blind." Actually, insofar as the therapist is the most normal member of the group, he often is the least productive contributor to the theragnostic process. It is true that the neurotic has unrealistic motives and perceptions in the adient or expressive phase of contact. However, when he is in a perceiving role, he is a highly critical and reliable observer, especially when checked by the reality of group consensus. Furthermore, comparisons of individual and group treatments, such as those made by Powdermaker and Frank (1953), show that in comparison with the pressure of group consensus, the individual therapist's influence is less effective in producing change.

Secondly, the above observations suggest that the group as a medium of psychotherapy can be effective only to the extent

that it is group- rather than therapist-centered. Only under a therapeutic group regime which permits and reinforces freedom of expression, and which refrains from imposed taboos and orders, can the observational and emotional sensitivity of the neurotic and psychotic members have its therapeutic impact. Such a group regime has a particular form of "culture," which emerges and grows under proper guidance. In order to provide his patients in the therapy group with a "culture" conducive to the unfolding of theragnostic processes, the contemporary psychotherapist expands his armament beyond personality dynamics, beyond communication and contact, and pays close attention to dynamic factors and forces that make a difference to the quality of the atmosphere of the therapy group. In this he attempts to apply what his research colleagues in sociology, social psychology and group dynamics have found to be important variables of group life. With the use of the group medium, the role of the psychotherapist has expanded. It includes not only an understanding of so-called "leadership techniques," but also a feeling for such group dynamic processes as group tension, culture development, and subgrouping. In Part III of this book we shall turn our attention to these group processes.

### Impairment of Contact Capacity as a Function of Cognitive Fixation

It is generally agreed among American psychotherapists that regardless of constitutionally limiting factors, every patient is potentially capable of improving his interpersonal relations beyond the improvement that is possible by the self-recognition of limitations in contact capacity (cf. Speer, 1949, 1951) and constitution as recommended by Kretschmer (1949). Every psychotherapeutic clinician since Freud has noticed in his daily work that dynamic aspect of neurosis which comes under the general heading of *cognitive fixations*. One of the best examples of a cognitive fixation which preoccupies the patient and thus reduces his efficient contact capacity is the well-known Oedipal conflict. Another example, first suggested by Adler, is the attempt on the part of the patient to put into reality a fiction about the self. In



the masculine protest of the female patient, one often finds a fixated fantasy wish for the ideal male, the knight in shining armor. The hostility and depression of such patients can often be understood as a reflection of the frustration experienced as a result of the inability of the masculine protest patient to externalize in the here-and-now reality contacts the cognitive fixation on having to find the ideal man.

Another way of putting these neurotic tendencies of our patients is to say that all our patients to some extent seek fulfillment in the here-and-now of their social environment of cognitively fixated fantasy wishes concerning the role of the self and the roles of others behaving toward the self in certain wished-for ways. It is reasonable to assume that the concentration and waste of energies in the search for externalization and fulfillment of these cognitive fixations would blur realistic perceptions and, furthermore, would restrict the patient's capacity for contact operations.

In the ahistorical approach to psychotherapy, we have found that the most therapeutic experience for the patient in group therapy is to recognize the nature of these cognitive fixations. That is to say, as soon as the patient is able to sense what kind of truly fantastic expectations he has concerning the effect of his own self on others and what he expects others to do for or to him, it seems as if a healthy, realistic sense within the person, the ego, can take hold and proceed to redirect energy into channels of more realistic behavior. The group situation is an ideal medium for the recognition of these cognitive fixations, for it is in the group that the patient's attempts to fulfill them and to externalize them are demonstrable. When, for example, a certain patient, after a year or more of group participation constantly warms up only to the more or less silent members, rejecting anyone who has made warm and active approaches to him, the unrealistic and socially inefficient nature of his energy expenditure becomes subject to majority group perception. The group's confrontation of this pattern to the patient exhibiting it follows. The result is the awakening of the ego's curiosity further to perceive and penetrate insightfully this pattern of behavior. Soon other cues, dreams, and spontaneous group behavior, help the group and the patient to see the fixated, previously unconscious



fantasy-goal structure that underlies the socially and personally unsatisfactory behavior response pattern.

While hunches and "insights" concerning the remote causes of these often quite strange fantasy fixations help the patient's ego in his surprise reaction to the group-mediated discoveries of these fixations, the major impetus to change seems to be quite independent of these historical perspectives. The major force to change and to dissolve the fixated fantasy goal structures of patients seems to spring quite simply from a clear recognition of their handicapping, and often dangerous self- and other-destructive, nature. The ego of the patient can be relied upon to master danger and handicap when the quality of this danger is fully recognized and appreciated by the ego. In speaking of full recognition, we wish to emphasize the fact that mere intellectual verbal labeling without a deep emotional feeling for the existence and quality of previously unconscious fantasy strivings simply fails to produce changes. Moreover, the glib labeling of "my neurotic patterns" is one of the many intellectual forms of resistance of the neurotic personality structure against change. It is a defense against allowing the emotions to participate in the cognitive processes of psychotherapy.

When we compare the emotional intensity of experience associated with historical insights with the emotional quality and intensity associated with insight into existing tendencies to externalize in the here-and-now and to seek fulfillment in the here-and-now of fixated fantasy gratifications, some resultant observations can be made. Insight into presumably initial causes in the remote childhood of the patient are usually mediated by the professional therapist's interpretation. They concern issues which, if not dead, have faded away. Insight into the here-and-now tendencies to set up the interpersonal environment to yield the unconsciously wished-for results are usually mediated by group consensus and peer reaction. They are alive and demonstrable in the present adjustment situation of the patient.

Historical insights consequently remain relatively intellectual, cognitive restructuralizations, while the ahistorical insight into now functioning, now directing behavior instigates strong emotional impulses toward change and toward seeking for the future

new goal patterns and new instrumental behavior. Since the participation of affect in therapeutic learning and cognitive processes is considered by all schools a favorable condition, conducive to efficient psychotherapeutic processes, it appears from the above observations that the task of the therapist is to facilitate as much as he can group-mediated insights into the here-and-now existing and externalized psychopathology in preference to using his influence in the direction of reinforcing the historical perspective.

In the ahistorical approach to group therapy each patient gets acquainted with the unrealistic, fantasy nature of his pseudo community (Cameron & Magaret, 1951) without necessarily making a rigid causal speculation of its origin. All that is necessary for deep therapeutic effect to take place is for the group consensus first, and for the patient thereafter, to sense the detailed design of how and what type of response he tends to "draw" from the others in the group. This gives a clue as to what peculiar gratification a patient is unconsciously seeking. Research in adaptive behavior of human and other organisms shows the capacity of organisms to avoid or otherwise master anxiety, pain, and frustration, once they can sense and see the nature of the dangerous or frustrating circumstances. Once patients can see what their fantasy needs are, they can go more intelligently about finding some fulfillment for them, if at all possible.

In group therapy, a full understanding of the defense mechanisms of the patients is of central importance. For the same emotional needs, such as the fantasy wish to be loved fully and exclusively, may be sought after in radically different defensive ways by different individual patients, who may all have the same unconscious need. While all group members may share the same anxiety, say on the occasion of experiencing that a group therapist is more interested in one particular, opposite sex patient, one patient may become aggressive about it, another very submissive, and so on. The presence of collective anxieties are noticeable only on the basis of heightened emotionality, communication blocks, and the like. Their presence is not signaled by aggressiveness or other "common" defensive manifestations. It is very helpful for the individual patient to recognize the particular quality of his "preferred mode of defense." In realistic

social life, people react to the overt defense patterns of others, that is, to the patterns of social role behavior.

Of great therapeutic importance to the individual, then, is seeing how his preferred social defense often is the very worst method to obtain gratification of the underlying need. The social role may be a symptom of a counterphobia to some very strong fantasy need. A clear example of this can be seen in the so-called "masculine protest" (Adler, 1946), that is, the aggressive women whose real unconscious wish-world is filled with a need for submissive, dependent "leaning" and being taken care of.

Peace of mind cannot be restored until a patient has the chance to fight directly for that which he really seeks and wishes, without the roadblocks of his own defenses. He must learn how his own preferred defense system is blocking, is diverting his energies from obtaining that interpersonal effectiveness that brings him closer to a fulfillment of his desires.

In our group therapy approach, in which the here-and-now is emphasized, cathartic release of pent-up emotions supposedly related to repressed childhood occurrences and wishes is easily triggered by the permissive atmosphere prevailing in therapy groups. We could produce many protocols of communications with regressive content which are characterized by strong emotional participation and discharge. One might say that these flights into the past in group therapy are the most popular form of resistance against coming to terms with a clarification of emotions in the present group therapy situation. Spontaneous regressions to conflicting aspects of the remote as well as of the more recent past are therefore daily occurrences in group therapy.

Ahistorical communications concerning interpersonal conflicts in the here-and-now context of the therapy group bring into the foreground patterns of interpersonal conflict and emotional personality characteristics of the self and of others. This fresh perception frequently mobilizes a historical background context in which experiences with similar patterns in past interpersonal frustrations are emotionally revived, acted out, or symbolically communicated. The most common misunderstandings about the ahistorical approach to personality problems are cleared up



when it is realized that the person, as part of his adjustment to a present stimulus situation, mobilizes all relevant aspects of the total organism, including his past time perspective. He generalizes backwards. The tension system of the psychoanalyst-patient pair is precisely the dynamic reason why in the isolated, private two-group individual analysis the patient turns so easily to reminiscences. Talking about the past is a symptom of the mobilization of the ego to deal with and master the unconscious forces and conflicts instigated by new interpersonal relationships, such as exist in the here-and-now, between the patient and his therapist and between the patient and his peers in the group. In our group approach there is an understanding that it is more helpful and anxiety-relieving to communicate whatever feelings, emotions, and evaluative attitudes are *presently* acute in the group than to escape into historical episodes.

We wish only to establish the point that much that is communicated in psychotherapy must be understood as an expression or symptom of the attempt to master the unconscious forces that are automatically mobilized in such human contacts. There are common situational forces of pairing and subgrouping. These are psychological factors which operate in addition to the private intradermal motivational structure, which contact between the patient and the others as individuals brings into the situation. These situational forces are, in the author's experience, as effective determiners of the patient's behavior as are their respective intradermal motivations. Or to put it differently, we need the postulation, not only of intradermal, but also of situational psychological forces to make sense from the interpersonal behavioral facts manifested in group psychotherapy.



## Chapter 15

### EGO GROWTH AND INDIVIDUAL SELF-DIFFERENTIATION AGAINST THE GROUP BACKGROUND

---

Behind participation in the process of intensive psychotherapy there is the very powerful desire to fulfill many vital, yet now frustrated or repressed gratifications. Among these is the desire deeply to experience being loved and belonging. The wish to be able to love genuinely and accept others is of fundamental motivational significance. The professional psychotherapist knows that this legitimate and normal aim of the patient can be reached only through a removal of unconscious road blocks of a more or less serious nature in the path of the patient's attempt to realize his inherent optimal growth potential. The patient should be able to take full advantage of the opportunities for gratification provided by a discriminative approach to and use of the environment.

While psychotherapists by no means unanimously agree in their theories of what these unconscious road blocks are, or what the best techniques may be to remove them, all share the view that whatever theory or approach is applied, these unconscious road blocks will yield only slowly. Only when the tools are carefully thought out and sensitively and patiently applied, during long hours of work, will the patient be able to wrestle constructively with his unconscious fears and conflicts. The serious work situation of the psychotherapist is, for the patient, a highly charged need situation into which the patient brings the very same thought and behavior patterns which have made him ill with himself and which have made others ill with him.

What are the peculiar conditions of the therapy meetings that differentiate them from the many other life contacts of the pa-

tient with other people with whom and through whom his neurotic condition came to his attention? Why is the neurosis not just continued and reinforced in the clinical setting, when it has grown in every other setting? What are the unique features that make interpersonal contact in group therapy therapeutic? What are the special, particular conditions which are responsible for the arrest, rather than the continuance of a psychopathological state in the patient?

### **"Operation Me"**

The first unique characteristic of the psychotherapy situation which differentiates it from every other life situation experienced by the patient before is the absence of a realistic objective or "project" outside the self or the "me." The patient does nothing and nothing is done to him or for him. He is forced to be purely "social." He does not come to sell the therapist something or to be sold something concrete. The patient walks into an artificial arrangement which is characterized by the absence of any of the usual realistic and logical purposes with which human intercourse ordinarily concerns itself.

The therapeutic process starts with the way a patient adjusts to this rather unique situation in his life by which he is involved in "operation me." How will he involve the therapist and his co-patients in operation me? How, after a while, does he experience this operation? The normal and healthy person who likes to expend his energies on realistic and constructive, objectively sharable, logical purposes would soon get bored and leave this peculiar field as one that "makes no sense."

It is true that most neurotic patients in need of therapy have this very same reaction initially. The experienced, dynamically oriented clinician can distinguish between the resistive significance of such a reaction on the part of a neurotically disturbed person, and a healthy rejection of an irrelevant diversion from realistic pursuits on the part of a healthy person who does not need intensive psychotherapy. As a matter of fact, the criterion for terminating participation in the psychotherapeutic environment is the point at which the psychotherapeutic environment no

longer has any useful meaning in the total pattern of realistic pursuits and purposes of the patient. With Rank (1947), we do not label the normal, mature person's resistance to psychological disassembling of the ego as "resistance" to a supposedly constructive process of removing "blind spots." Our purpose is limited to the rehabilitation of characterologically and psychosomatically handicapped individuals.

For the disordered person, "operation me," far from being an irrelevant, boring fight with obscure windmills of the mind, becomes a busy and exhausting project of central, personal significance. Good initial rapport and a permissive atmosphere trigger the neurotic's strong unconscious needs to engage others compulsively and repetitively in unrealistic set-up operations (cf. the definition of set-up operation in the previous Chapter. In other words, "operation me" consists of making the patient extremely busy, for a long time, with a painful struggle to maneuver, seduce, cajole, and force others in the therapy group (therapists and co-patients) into reciprocal behavior patterns which might dovetail with this set-up operation. This, it is vainly hoped, might achieve results in harmony with unconscious fantasies, and thus insure the tasting of unconsciously longed-for neurotic gratifications. But, unfortunately, the struggle always ends in defeat: every friendly and accepting opportunity extended to neurotic individuals for the realistic enjoyment of natural relationships is never experienced as really gratifying, but is repeatedly twisted into experiences of frustration, disappointment, anger, depression, impotence, or sheer confusion.

In the artificial setting of the therapy group, the experience of neurotic anger associated with failure to fulfill fantasy gratifications, natural or perverse, is curiously felt and communicated. But, and here is a crucial difference between realistic social environment and group therapy environment, in the therapy group the disappointment is even greater and more painful than in real life because the therapeutic situation was consciously anticipated as an ego-strengthening and gratifying process. Yet the process is painful and anxiety evoking. But while the disappointment is unpleasant, it is less frightening because the therapy situation is a safe place to experience neurotic disappointments without real-



istically damaging consequences. This safety permits a "stop and look" attitude, a free examination of the sequence that led to the experienced disappointment.

Sharing with others who are equally disappointed in mutual set-up operation attempts is an important feature of the therapy situation. This feature differentiates participation in group therapy from participation in real social life. It makes anxiety and neurotic anger easier for the ego of the patient to bear. This is especially so, since the trained authority of the therapist uses his weight to support and to accept the catharsis of neurotic tensions and frustration-induced hostilities toward himself. In ordinary life, authority is used to point out and judge the unrealistic, "unnecessary" nature of these neurotic set-up operations. In contrast the professional therapist uses the weight of his authority to help strengthen those features of the group therapy situation that will insure many "repeat performances" of these attempted neurotic set-up operations with repeated failures of the fantasies to materialize. The therapist also reinforces the group's attention to these processes. This again is contrary to real social life, which by its customs can almost be defined, on a superficial level at least, as a situation created to reinforce rational reality and to avoid, under most circumstances, the "free expression" and externalization of fantasies.

As group therapy sessions are repeated and time goes on, all participants learn by experience that it is safe to behave unashamedly and "freely neurotic" toward each other and toward the therapist in this special and peculiar situation; they soon can see and feel what their own neurotic behavior does in the way of complicating the life of the me and the life of others in the group. Then they have the first chance in their life really to see how their set-up fantasies interfere with their own gratifications, their own normal wish to be loved, and to be able to love in the real life outside the therapy group.

It is through the obvious and repeated disjunctive effects of neurotic behavior on the majority of the group, which the group majority is very keen to point out, that the patient eventually becomes quite familiar with the quality and nature of his set-up operations and with the fantasy wishes and fears which are the



driving forces behind his compulsive and repetitive behavior. Then he can abreact, undergo catharsis, and confess the often infantile, frequently perverse, sometimes very unrealistic or "simple" fantasied quests and fears. For now his own ego, however weak it may be, becomes the enemy, not of his quest for gratifications, but of the fantasies and his acting-out manifestations that block them. Here again the real social environment would in contrast judge and expel, and not tolerate such externalizations and manifestations of wishes and fears.

The realistic social environment requires extra-ego attention. Western culture does not reward self-contemplation. Realistic society is mainly organized to master material and economic phenomena. But the peculiar environment or "culture" of the therapy group not only tolerates but congratulates the successful patients on their externalization, or, if you wish to be dramatic, "expulsion of the devil." That is, agreement with the group's recognition of the nature of the fixated fantasies within him for all kinds of experiences with others earns high status in the group. The congratulations are justified because a bit of reality enters, not necessarily by way of a conscious label, but nevertheless becoming manifest in a sense that no one in the therapy group, and no one in the larger world, could possibly be able to "oblige," reciprocate, and dovetail in these fantastic set-up operations.

The unreality, the fantastic nature of the fixated patterns of the patient, becomes a reality in the therapy group. This sensing is often accompanied by a feeling of loss, by what we would like to call a "therapeutic depression": a loss of morale before new goals are established and new patterns of realistically available gratifications are tried out.

We have noted earlier a factor which counteracts the therapeutic depression: in the therapeutic group the self-probing and self-exposing of the unconscious is significantly rewarded by gaining high status, increased prestige, and power to influence others effectively. It is an interesting manifestation of the unconscious mutual aid in man that often in therapy groups the most helpless, most traumatized patient has a very high prestige in the group, provided he can shed his defenses and "work on" the recognition of his intensively fixated fantasies.

While this process of externalization is anxiety-evoking, the patient is never alone. "Collective anxieties" assure him that so many of his infantile, unrealistic dreams, wishes, and fears are shared in different forms by most in the group. Particularly reassuring is the communication by advanced patients that they, too, once used to have similar fantasies and that they have now changed in their wish and goal structure so as to deal more realistically with their interpersonal environment.

### **New Learning**

So far detection and discovery of that which was before unconscious occupied the major theme of "operation me." But now along with it and following it there is a reconstructive, or new learning process going on. This process, mostly unlabeled, is just experienced as interesting and gratifying. The patient is now able to try out more conjunctive ways of contacting and of relating himself to others in the group. He has discovered that his energies, freed from the need to prepare for fantasied battles and triumphs, can now be used in opening the self to others. Now others can be realistically discerned with respect to their suitability for gratifying contact operations. Naturally, the formerly neurotic patient is a novice at this and quite hesitant in his early tryouts. But soon he can see new opportunities for fulfilling long desired gratifications. Soon he is willing to engage in the preparatory social field work which is necessary to gain and maintain reciprocally satisfying contact operations in the group. He finds his own company no longer unbearable. Rather, the rehabilitated patient begins to economize on his emotionally significant contacts, choosing them more carefully and developing the relationship more fully.

### **"Operation We"**

Through repeated experience in group participation, the slowly "graduating" patient gradually sheds or is reconditioning many of his unrealistic strivings. He changes his perception of

the world around him. Experiences of communication blocks and emotional tensions on hundreds of repeated occasions during his therapy group participation have deeply impressed him with how much "operation me" is interdependent upon the forces that maintain the functioning of the "we." These experiences have also impressed him with the difference that his own actions can make in the conditions of the group life. The previously experienced formidable group of strangers "run" by some power or authority to which he, the individual, had no choice other than to comply has made room for a conscious appreciation of one's own participative effect on the function of the "we." The participative, self-governing atmosphere stresses the respect for each group member's explicit right to determine the nature of the group life which is to influence his personality and outlook. This again is a unique life experience which is in stark contrast to the usual lack of real determinative participation in the management of ordinary group living in the patient's real social world. It is customary in reality groups such as the family to accept existing roles and ritualistic patterns with a minimum of management participation on the part of all members. Having tasted the ego-strengthening flavor of group participation within the artificial group therapy environment makes the graduating patient ready to seek and create similar opportunities for participative group living in his family, work, political, and play groups.

It would, however, be grossly misleading to infer from these observations of our "graduating" patients that intensive group psychotherapy has made them forever group-bound or "group addicted." If they are, they are not yet in the "graduating" class. Patients grow through a phase in which they are all "hepped" on involving themselves in in-group affairs, in having deep "we feelings," in concern with the "sickness of the group." Often such extreme preoccupation with the "we" is a diversionary, resistance maneuver against being concerned with "operation me." The patient's undue concern with "analyzing the group" is analogous to the defensive attempt to be preoccupied with the person and mental health of the psychotherapist in the individual technique. The truly graduating and graduated patient's attitude



toward the group is quite different. It contains a realistic appreciation for how great a job it really is to have a healthy and well-functioning "we." Having repeatedly experienced how inevitable group tensions arise from the very existence of and maintenance of the group, and how these tensions may seriously interfere with the pursuit of good personal satisfaction, has made the graduating therapy group member highly appreciative of the limits of satisfactions derivable from the group and the need to develop a relatively independent individuality to obtain self-gratifications.

Free communications of feelings and wishes in the therapy group make possible deeper observations of others than is possible in everyday life, or in individual therapy. In group therapy "insight into others turns into self-insight." This transformation has been described in our discussion of advice giving, where it was noted how the patient learns in the group that his perception of others is largely determined by his own overt or latent needs. Each patient eventually identifies with the therapist's tendency to ask the analysts of others in the group, "what within you makes you such an acute perceiver of such and such a tendency in the other?" At first, the new patient is puzzled by this unaccustomed method of having a supposedly objective perception of someone else implicitly turn out to be a perception of the self. But soon he is able to follow the lead of the more advanced patients in the group. The latter have for some time recognized the value, to themselves, of examining the motivational basis within their own ego—for their particular perceptual acuities. This appreciation on the part of more advanced patients is reinforced by the discovery that certain individuals gain special status in the group through their expert perceptions and special sensitivities.

In the multidimensional reactions of members in the group to the same interpersonal problem situation, it becomes clear to everyone how difficult it is for everyone to approach the same problem in the same way, how much more natural it is to reach out into life in individualistic ways that are held down by fear. Fear dilutes ego boundary and holds up the need for copying and identifying with how "George does it."



## Individuality and Group Consensus

Repeatedly, majority group perceptions expose the neurotic fear of individuality and the neurotic wish to hide in the group, to be just one of the "lonely crowd." Riesman (1950) has described the American mass neurosis of "doing what everybody else does." We run across an apparent paradox of group therapy: through group consensus, which after all is made possible by several individuals thinking and perceiving processes in the same way, individuality can be strengthened. The group consensus functions in the work phase of the life of the therapy group, not only as a method of establishing social reality, but also as an ego-building force. In other words, in its work phase the group not only uncovers destructive discrepancies between wish structure or ideal self and actual behavior and actual self, but it also exerts pressure on and stands behind the patient's attempt to change and to go after his real wishes in new ways. In this connection it has been noted by many group therapists that changes in the patient's behavior patterns are greatly facilitated if his new ideas have the collective backing of his peers in the therapy group (cf. Powdermaker & Frank, 1953).

The group consensus can not be naïvely thought of as a pressure toward behaving nonindividualistically. On the contrary, the group does not demand that the individual patient behave in the same way as everyone else, but rather the majority of the group is united in its perception that such and such behavior change would be good and constructive for a person. If the individual patient feels a strong sense of belonging to the group, he will eventually be influenced effectively by such group pressure, for he can say to himself, "Since they all feel that this would be good for me, they cannot all be wrong. Maybe I should try it out."

Through the work phase of the life of the therapy group, members acquire a tolerance and even a liking for individuality. In the work phase members and therapist help each other, not only to see, experience, and learn how they themselves approach emotional and contact problems, but they also facilitate the formation

of "learning sets" (Harlow, 1949) or what Bateson (1942) has called "deutero learnings." Group therapists can "teach" group members how to learn from each other, which includes learning how to differentiate oneself, one's own needs, one's personality, one's ways of doing things individualistically, and one's tolerance for such individualistic doings by others. This self-differentiating process strengthens the boundary of the ego and reduces the intensity of contact needs. As soon as contact needs have attained normal levels of intensity, the individual will gain realistic satisfaction. Group therapy makes the patient more sensitive to his individual ego, to his individual requirements, and to the difficulties and challenge to bring about the sphere of influence in which the individual can more happily discharge his tensions. Through group therapy, patients realize that a co-operative group life is possible, that such a group life need not be based on commonality and similarity, but rather on coordination and complementation of different roles and different qualities. The central therapeutic experience for the participant in group therapy is differentiation and individualization. The group therapy setting is the best possible living laboratory for self-differentiation.

In the final phase the graduating patient finds his own activities more creative in the sense of feelings of self-fulfillment (C. Bühler, 1952*a*). He ventures into and experiments with new thoughts, new activities, new people. The ground under his feet has changed. He has removed from his eyes the distorting prism of blue-hazed fantasy and is curious to explore the old world with a new look. Before he leaves the therapy group he has experienced all the old figures of his therapy environment, his co-patients, his therapists, even the physical environment of the office and clinic, in this new light. And in this new light, he sees this peculiar environment as a healthy and normal person would see it: as a peculiar and artificial situation, specifically created to catch, arrest, work through, and outgrow the neurotic dissatisfaction with the self and his insecurity with others, even when loved and respected. Participation in this peculiar environment no longer makes any realistic sense. It does not provide realistic gratification. Life outside beckons for really gratifying actions

and contacts. In contrast, the therapy environment fades in stimulus value. It soon will be left behind as a particularly difficult and painful phase of growth, a hard, working experience that built the launching gear for a new and better life and person.

Therapy group members "attack" each other's defense mechanisms, especially since they are affected by them. A great variety of defense structures is today common knowledge among all professional psychotherapists, regardless of theoretical orientation. Nonpsychologists, too, are capable of recognizing the preferred defenses of any personality, if sufficient opportunity for intimate social contact and observation is provided. Group therapy is a situation which encourages the recognition of the particular quality of these defenses. Since patients in a therapy group directly affect each other by the nature of their defenses, discrimination between "good," socially conjunctive, and "bad," socially disjunctive defenses are automatically made. To the extent that the "bad" parts of an individual's defense system are recognized as instigating communication difficulties (anxiety evocations) for everyone present, pressure toward change is always applied by the majority group.

This pressure, however, is rarely successful in producing change directly. Unless the patient escapes by way of a counterphobic pseudo cure, the stubborn persistence and repetitive manifestation of a recognized "bad" defense pattern soon signifies that the so-called "bad" defense serves a "good" purpose in the sense that it is needed by the psychologically ill person as a method for avoiding the expression of unconscious wishes and needs which are feared. Another part of the group therapeutic process likewise deserves recognition: the process of discovering that it is safe in the group to give free expression to previously repressed wishes and fears. What makes it safe in the group is the process of what Sternbach (1947) and other theoreticians of the group therapeutic process, such as Wolf (1949-50), have referred to as the process of *identification of the individual with the group ego*, or internalization of group values. The fact that all members share to certain degrees in the possession of the same unconscious motives, as, for example, infantile dependency (Oedipal fixations), and homosexuality, makes possible the direction of



majority group pressure toward the affirmation and acceptance of these unconscious forces.

While the two processes (1) recognition of "bad" defenses, and (2) discovery of unconscious strivings and fears, are evolving, a third development, a particular characteristic of group participation, takes place: (3) ego strengthening through the discovery and use of new interpersonal gratifications, such as are inherent in experiencing a mastery of the group's previously felt opposition to the individual's quest for personal satisfaction.

### **Mastery of the Conflict Between Individual Gratification and Group Membership**

Many observers of personality and social process have pointed to the conflict between individuality and dependency on the group. Rank (1947) hypothesized that "guilt feelings" are entailed in the individual's desire to be independent of the group. We view Rank's "guilt feelings" as a low morale state over the group's failure to satisfy the individual. In group therapy, the tendency to escape from the group is a reaction to an inability to make self-gratifying use of the group, resulting from an unresolved conflict between the individual's needs and the need of the group to regulate its life. This latent anxiety may find overt expression in several forms, one of which is the tendency to break up the group. The consequent anxiety is relieved by attempts at restitution following the hostile act. This restitution may take such forms as reconstructing the group's goal, or "pitching in" and making a "good meeting" out of a spoiled one. The psychotherapist tries to recognize and to reflect back to the members of a therapy group any existing discrepancies between a given individual's direction and pace of goal locomotion and that of the group's. For example, the individual patient's wish may be to escape or hide from the group, while the group may push toward full participation of all members. Tension then arises in both individual and group, owing to the fact that some conflict already exists between individual gratification and the group's goal locomotion.

Freud (1914), over thirty years ago, pointed to the superego-releasing function of the group. It is indeed true that patients



and others in group situations show under certain circumstances much freer expressions of emotions than they are ever observed to show under individual circumstances. Dollard *et al.* (1939) have analyzed this experience with respect to aggressive behavior in lynching mobs and have shown under what group and leadership conditions otherwise impulse-controlled individuals will join to provide for themselves and each other an orgy-like release of hostile tensions.

Groups only appear to facilitate obtaining instinctual and emotional satisfactions of the individual. Actually, the human group judges its members and limits their freedom of movement by taboos. Sanctions regulate how much, what kinds, and in which form, the individual may indulge in individual gratifications. There are always certain taboos placed upon excessive indulgence in individual satisfactions during group meetings. Basically, participation in group activities is really aimed by each individual at consummation of sexual and other personal satisfactions. The interplay of all individuals attempting to make use of the group for personal satisfaction requires, paradoxically, that each group member participate in developing and enforcing group goals and norms which actually put limits on his own and others' quests for obtaining individual gratification. Thus, while all in the group have a similar goal in obtaining gratifications, such similarity does necessarily contribute toward tension and conflict to a point where similarity of interest often destroys the existence of a group altogether. When everyone in the group has the wish to obtain the same gratification at the same time, the "common emotions" would constitute a situation antithetical both to individual gratification and cohesive group life.

A certain degree of personal maturity, as well as the existence of a communication-facilitating culture setting is a necessary condition that must be fulfilled before the individual can master the potential conflict between the individual and the group, and can utilize his group participation for maximal individual satisfactions. Participation in the therapy group as a total emotional experience "trains" each patient in the cooperative manipulation of an intimate face-to-face group for the purpose of enlightened self-interest and self-gratifications. Several hundred hours of

emotional experiences with the sometimes painful and tension-evoking, sometimes releasing and gratifying results of his attempts to make self-gratifying use of the therapy group, leave, at the conclusion of his psychotherapy, an indelible impression, the quality of which is hard to put under one label. The following ego processes may be suggested: experiencing and accepting the self as wanted by others, making a significant difference in the life roles of others, experiencing and accepting the nature of path and means-end relationships (Tolman, 1949) involved in gaining satisfactions through contact with others, avoiding or mastering conflicts and frustrations, and experiencing pleasure from individuality and self-differentiation.

The answer to the question of how and why neurotic and psychosomatically suffering patients get better through intensive group psychotherapy seems, in our opinion, to lie close to this fact: in such a setting patients repeatedly experience mastery of hundreds of interpersonal conflict situations. These conflicts arise because the individual requires group association for maximal need satisfaction, while at the same time others in the group are trying to use the group for the same thing. As the patient gets acclimatized to the realities of the difficulties inherent in making efficient use of the group, all the previously suppressed and latent ingenuities and potentialities for relating himself to others in firm and constructive ways are mobilized. The patient is thus learning how to get to and enjoy realistically available and welcoming objects. He is "reconditioning" the channels of gratification previously fixated on the nonallowed, nonavailable, "evil," rejecting, fantasied objects. The patient feels that he "makes a difference," that his contributions to the group and to other members are appreciated.

Through this new mastery, the strength of the original unconscious conflicts are reduced or substituted by the satisfactions gained from the ego's contributions to the group. Full awareness on the part of the individual patient of how the combination of his particular "bad defenses" and his particular unconscious strivings can lead to actual fulfillment, and satisfaction motivate him to explore sincerely all the possibilities of changing this frustrating character situation.

## Personality Changes

The group is the first experimental social ground for this new growth and expansion of the ego. The group's intolerance of seeking satisfactions in neurotic, defensive ways, and sharing honestly all impulses, makes it impossible for any patient to remain in the group for long without changing his character. As an expression of his belonging to the group, his identification with the group ego or the value system of the group, he must change his ways of obtaining gratification through the other members. In other words, he must become a different person in his intercourse with the group members. Since in our regime contact between the patients is very intensive and extensive, it is reasonable to hypothesize that the changes in character and conduct which are made within the group over two or three years of participation in it have enduring effects and carry over to the patient's character and conduct with people outside the therapy group.

Change of conduct and character is not simply a change of role or social technique, but involves a fundamental change of the patient's unrealistic strivings. By remaining in the group long enough, that is, from eighteen to fifty months, the patient signifies that he actually experiences change. Our follow-up data show this repeatedly. Patients who leave our group therapy program before eighteen months usually do not change in their basic motivational structure, but have used the group for experiencing their desires "to be accepted as is" and thus gain some of the growth-inspiring ego-strengthening experience so well described by Rogers (1951). The patient who stays beyond eighteen months shows his willingness really to give up his wish to be accepted as is, and to learn new ways of interpersonal communication which realistically lead to gratifying experiences with a minimum of conflict and anxiety, and a maximum of gratification.

A final step is the group's response to individual change by changing in turn its own attitudes, giving high prestige to any member who demonstrates that he is in the process of acquiring realistically effective ways of obtaining a constructive integra-



tion of satisfying inner needs and is maintaining conjunctive contact. Repeated reinforcement of the new character structure in the world outside the group eventually renders the group therapy milieu obsolete and frees the patient for independent growth in his natural community.

Foulkes (1948) and, independently, Thomas Gordon (1951a) have advanced the hypothesis that the major personality changes that patients undergo as a result of group therapy participation derive from the opportunity that such participation affords in (1) experiencing new ways of relating to others, and (2) the correction of the patient's dependence on authority. These two unique features of the group therapeutic process can be stated in terms of the following two hypotheses:

1. *The therapeutic process is in large part mediated by peers, rather than by authority.* One of several corollaries to this statement would be: In peer-mediated psychotherapy, transferred or real authority problems, which often limit the effectiveness of depth psychotherapy in the individual doctor-patient relationship, can be worked through with less anxiety and fewer threats to the ego than are encountered in individual therapy. The peer-patient group is a place in which authority problems can be keenly sensed by the patient, and yet, because of the always present group support "against" authority (as neurotic as such support may be judged to be), threats to the ego may be dissipated while important insight is conserved and integrated.

2. *Group psychotherapy participation is a social perception laboratory.* It is an experience conducive to testing and perceiving the reality and neurotic effects of the self on others, the effect of others on the self, and the discrepancy between inner self pictures, as well as inner-other relations to self cognitions. This perceptual discrimination process occurs on all levels of psychological analyses, overt behavior, conscious but private self pictures, and unconscious motivation. These levels of psychological processes have recently been given formal expression by Leary (1946).

For our purposes, it suffices to distinguish between the two levels of the discrimination of overt processes, and the recognition of covert psychological processes. In other words, we would say



that group therapy mediates discrimination learning on the following two levels: (a) the level of overt social adjustment, and (b) the covert level of neurotic acting-out of set-up fantasies. In the first place behavior patterns having realistic disjunctive or conjunctive effects in the self and seen in others are differentiated. Secondly, the perceptual discovery of unconscious motives leads to repeated demonstrations of the existence of pathological tendencies. This repeated externalization of unconscious motives facilitates full acceptance on the part of the person of the nature of his unconscious problems, which may be, for example, a strong castration complex or fear of realistic productivity and aggressiveness. On this level of introspective, symbolic language (drawings, dreams, and free association) the group's participation allows freer access to the unconscious of others.

Sharing the unconscious self thus lifts inhibitions against communicating symbol thought to the self. The censor becomes less strict as patients find that their unconscious needs are similar. Thus, self-perception of the unconscious is facilitated by the reduction of anxiety which comes about through sharing a mastery of the fear of recognizing discrepancy between the unconscious structure of motives and the structure of consciously rationalizable behavior patterns.

Group psychotherapy is an aid in the reorientation of *the individual as a whole* from a forced preoccupation with highly selective aspects of human interdependence, such as the young child's Oedipal problems, or his sibling rivalry, or his authority dependency. The direction of the group therapeutic process is toward a widening of horizon, and an increased freedom of locomotion which expresses itself in increased experimentation with new interpersonal techniques, techniques for which there was no room in the earlier life spaces of the individual.

We see the neurotic patient as filled with fixated response tendencies. He had too much of conditioned reflex learning, too much reinforcement of fantasies, too little opportunity for "extinguishing" fantasy reactions, which prevented insights, "aha" experiences, and closures. The neurotic, according to our present view, did not have the chance to gain insight into either reality or fantasy. What he learned was very similar to what

Pavlov's dogs or Hull's rats (1943) were forced to learn by rote: that some arbitrary, unnatural, "nonbelonging" stimulus, such as a neurotic behavior pattern, will lead to drive reduction.

In other words, our patients have been falsely conditioned to expect that some childlike or unnatural response pattern produces certain results in life. The children of neurotic parents have to learn without insight, by rote and repetitive experience, that the attention of the particular parental couple is best gained by pouting and asthmatic breathing. Because of the rigidity of the neurotic parents, and their superior stronger power field over the children and the secondary gain of these response patterns, there results an overlearning of peculiar mechanisms for solving and mastering one's interdependency with important others. Naturally, later on in adulthood, when these and other neurotic methods no longer work in the very different social fields of adult-peer living, the patients' need tensions remain unreleased, and he is in dire need to be helped, by psychotherapy, to reorganize his situation and learn to do something new and different about it.

The acquisition of neurosis has been fairly successfully expressed in stimulus-response conditioned-reflex terminology as overlearning of a peculiar way of mastering specific interpersonal situations which are not representative of the interpersonal dynamics essential to adult happiness. The actual process of human learning in the here-and-now of the therapeutic situation requires a penetrating analysis of the nature of stimulus-field-person interdependency. The ground-breaking study on perception of movement by Max Wertheimer (1912) encouraged psychologists of the Gestalt or field theoretical school to explore the higher mental functions by which the human person creates meaning for himself in life.

### The Gestalt Approach to Psychotherapy

Gestalt therapists have contributed knowledge of the conditions under which the perceptions of new situations and the solution of the problems raised by them, including the overcoming of rigidity and repetition compulsions, are facilitated. One of the oldest and traditional problems of Gestalt psychology is the

"shift" or *Einstellung*, first studied on so-called ambiguous figures. The actual process of the reorientation of the neurotic rather than the *post facto* "explanation" of how he got that way are the concern of the Gestalt and field-oriented psychologists. It was a natural consequence of this approach to demonstrate experimentally, as Kurt Lewin (1943a) did, that it was easier for the individual to shift his emotional attitudes, goal, and approach-avoidance tendency into new directions required by new conditions of the social field if he could make this shift in conjunction with the decision of a group to which he felt he belonged, as compared to making the change on his own "reasoning" or "discrimination."

The spontaneous learning, the deutero learning talked about by Bateson (1942), which expresses itself in psychotherapeutic learning how to learn and in the explorations of the child and the scientist into new ways of perceiving and of doing things, always presupposes a certain degree of freedom from repetition compulsions produced by histories, peculiarly unrepresentative of presently available behavior potentialities. This freedom is first gained for the neurotic by learning to partake of the freedom of locomotion and exploration offered in the therapy group, while the intensity of the two-person situation and its similarity to early and peculiar parent-child situations makes it an easy condition for the reawakening of overlearned dependency reactions and a difficult condition for learning new methods for solving his problems.

### Libido Management

Closely related to the generally expressed hypothesis that group therapy patients particularly learn to rid themselves of authority dependence and their fixated quests for archaic identifications with parental figures, is the idea expressed by Sternbach (1947) that group therapy experience proves to the patient "that renunciation of infantile libido and hostility is rewarded by more mature love gratifications and security. It must impress him by the fact that the group leadership is subject to group interest." We have seen in Chapter 8 the libidinal significance of helping,



of advising, of interpreting. We have noted that one can talk about these repeated experiences of group therapy participants as exercises in libido management. In less formal language, one may say that the patient liberates a reservoir of libidinal energy, which up to now seemed to be reserved for some specific—now unrealistic—objects, perhaps the original incestuous objects of father, mother, sisters and brothers, and their derivatives. Through repeated friendly and yet seriously analytic contact with the same patients in cohesive group therapy living, the patient tastes, perhaps for the first time, the emotional gratification of being able to “open up” to real figures in his here-and-now contacts, and as he repeatedly tastes and digests this psychological food, his approach to the realistically available compeer object is strengthened and, reciprocally, the strength of his fixation on the old fantasy objects weakens.

In still another sense this type of experience liberates narrowly fixated libidinal object strivings. Neurotic patients notoriously have a very narrow concept of sexual gratification, as their masturbatory fantasies clearly demonstrate. Another sign of this is the tendency of our patients to compartmentalize sexual activity, to segregate it as something special. In doing so, the actual consummatory act of sex becomes highly charged with anxiety, instead of taking a relatively less dramatized place in the total life space of the individual. Through participating in social intercourse with compeers in the group, which is highly libidinalized yet only very rarely develops into actual sexual consummation, this compartmentalization and limited dramatization of sex is largely dissolved. The patient learns, so to speak, to spread libidinal stimulation all over his social map.

This change can be seen in the progress all patients make in being more comfortable around the opposite sex in social situations, being able to enjoy contact with the opposite sex in conversation, dancing, work, sports, and other activities. Through this experience, patients are able to feel warmly toward the opposite sex without having the compulsive urge to jump into bed with everyone, or having to offer themselves to every object that shows interest. We believe that the process of learning to manage, not only sex, but also aggressive impulses, in constructive



and socially realistic ways comes close to the core of the psychotherapeutic benefits of group therapy participation.

### **Learning to Derive Individual Gratifications Through Group Participation**

Our understanding of the psychotherapeutic process mediated by therapy group participation must touch at this point on the value structure of the macrocommunity within which the patients live. The West European and North American culture orbit has progressed to a point where ideologically the group is seen as a vehicle for the expansion of individual psychobiological gratifications and the individual's political-economic security. The family as a grouping for the sexual satisfaction of the mature organism and the fulfillment of the dependency needs of its immature members is the usual example of how group association and individual need reduction and satisfaction are closely related. From this interdependence of group and individual there arises the potentiality for conflict and tension between individual members of the same group.

The individual's dilemma arises from the fact that he needs group participation to assure for himself any kind of chance for fullest individual gratifications (such activities always involve communication and exchange with others) yet this group participation is not always easy. The degree of efficiency in group participation does not depend only on personality growth and past interpersonal experiences; it also depends on the particular phase of group life which coincides with the presence and arousal of individual needs and their satisfaction. Certain phases of life in the therapy group favor the satisfaction of the therapeutic needs of the patients, while others do not.

## Chapter 16

### DEVELOPMENTAL PHASES IN THE THERAPEUTIC GROWTH PROCESS

---

The task before us is to relate the process of group development to the therapeutic growth of the individual patient participating in the group. The exploration of the relationship between the cultural development of the therapy group is stimulated by our impression that it is impossible for the individual to grow psychologically without a concomitant change in the group atmosphere to which he belongs. Consequently, a group therapist cannot be satisfied to be a therapist to the individual in isolation; he must also be a therapist of the group. He must facilitate the growth of the group from its initial states of immature assembly to the more mature states of therapeutically significant communication.

The practice of psychotherapy with continuous groups has made it possible to study different phases of group life. All practitioners of group therapy have observed that a continuous change takes place in the life of the same therapy group. When three or four groups are going at the same time under the same therapist, a certain regularity and lawfulness of group development can be observed. For example, it is very apparent that a new therapy group, which has met fewer than fifty times, represents a very different field of communication from a therapy group which has met for over three hundred times.

#### Seven Developmental Phases

Therapy groups grow from an initial interpersonal *testing phase* to a fairly stable clinical *work phase*. In this progression one can speak as if the group passes through seven phases. Using

the concept of phases, we do not imply orderly succession; rather we should say that we provide ourselves with an orderly model of a very varied process. We do not imply that there is a firm and orderly sequence of therapy group development. While in our phase model we try to eliminate confusing overlaps and define each phase distinctly, no such categorization actually corresponds to the natural flux of group life. Empirically speaking, in any given two-minute period of a therapy group meeting, a team of astute observers may find defensible evidence of the simultaneous overlap of several of the following phases:

- Phase I: Initial Situation Testing
- Phase II: Leader Dependence
- Phase III: Familial Regressive
- Phase IV: Associative Compeering
- Phase V: Fantasy and Play
- Phase VI: In-Group Consciousness
- Phase VII: The Work Group

The author believes that it would be repetitious for the reader if at this point he were to give an elaborate description of each of these seven phases. The seven phases of group development are related to themes and activities, as indicated in Table I (Chapter 6), which correlates different themes to the various phases. For example, the group formation processes are representative of the initial situation testing phase. The initial resistance to group therapy (cf. Chapter 4), as well as group tensions arising from the leader's refusal to cater too much to dependency needs, highlights the activities of Phase II: leader dependence. In Chapter 18 the reader will find a discussion of the conditions under which therapy groups engage in a regressive, familial type of intercourse. By referring to that chapter the reader can envision the nature of Phase III, the familial regressive phase of group growth. Also in the same chapter (Chapter 18), the associative, compeering atmosphere is described, which is relevant to the fourth phase. Phase V, fantasy and play, is best exemplified by the socializing and role-playing themes. In-group consciousness (Phase VI) is a label for the great amount of interest which under certain conditions the group mem-

bers show in pairing and subgrouping. This interest is discussed in Chapter 22. The final or work group phase (Phase VII) is a characteristic of what Bion (1948-51) has called "the sophisticated group." The work group phase is characterized by the theragnostic work themes described in Chapter 12. In this advanced stage of group development, the nucleus of the group has become aware of and recognizes what Bion (1948-51) calls the "need for truth as a criterion in the evaluation of their (the group's) findings."

It can be postulated that the group as a total organism has experienced throughout the previous phases of its life the advantage of attempting to establish a social reality. It may, perhaps, be more precise to say that throughout the earlier phases we cannot really speak of an established group, but rather speak of the *development* of an established group. Thus, the group developmental phases are not phases of mature group life, but rather phases of group development from assembly to a stable group. The stability of the loose group is reached when the majority of the group membership has truly accepted membership on the basis of the tension-reducing experiences which were experienced as helpful to the individual's growth. As nuclear members experience again and again the value of using the group as a reality check, as well as a safe place to examine the fantasy structure, they prefer to make use of the group primarily on the more advanced, work phase level.

### Clinical Implications of the Work Phase

The efficiency of the group method of psychotherapy stands and falls with the question of reaching an appreciation of the group as a place for reality testing. The achievement of cohesiveness between members, of group-centeredness, instead of leader dependency, is possible only when the group, not the therapist alone, is seen as representing social reality. Only a cohesive group develops a "group ego" which permits each member to feel safe enough to function in a free, creative manner of communication. The fourth developmental phase makes it possible for every member to experience a sense of value within the group,



because attention is focused on phenomena and processes which are subject to the here-and-now observation and participation of everyone present. This distinguishes early from later phases. In the early phases, everyone feels that the "true" significance of dreams and other communications escapes the group, while it supposedly does not escape the professional therapist. In the later phases all members participate in the analytic work.

Experiencing the social interdependency of individual and group is considered of central therapeutic significance. One of the functions of the group therapist is to facilitate the recognition by the patient of such interdependency. Patients become aware of the factors that may affect or change the nature of group dynamics. Such insights enable them to assess the part their personalities can play in determining the fate of their own social fields. The group setting affords an opportunity to do therapeutic "exercises" and experiments in social field maintenance as follows:

1. Patients perceive some of the conditions of the social field which they can to some extent control.
2. Patients participate in the process by which the individuals in the group learn to free themselves from unconstructive leader-dependency. The professional group therapist makes it possible for the group better to self-determine its own development, including how to adjust better to the presence of himself, the expert.
3. Patients, by taking responsibility for the quality of their own group's culture, have new growth experiences. The therapist helps patients to recognize the crucial points in the stream of the group life at which the group by decision, sanction, or clarification can or could change the course and depth of its own social field.

The above "therapeutic exercises" are really training experiences in social field maintenance. The patient is given an opportunity to come to his own terms with life, to discriminate and choose among his contacts, to shed ego-alien interests and values. The patient gains strength and satisfaction through preparing this field of gratifying interpersonal relationships, rather than depending on others to provide contact considered "good" for him.

Many patients suffer from a condition that may be para-

phrased as "*weaning, past due*," weaning from unconscious, fixated anticipations of familial gratifications, weaning from inappropriate identification with models provided by the biological and cultural accidents of early family grouping. All these weaning processes are close to the core of the group psychotherapeutic process.

Only a clinical management which is group-centered rather than doctor-centered can stimulate and support the group's growth toward the work phase. Patients must be given the opportunity to learn how to become participatingly involved in controlling and leading their own lives. The group medium should be a stage for the recognition of the previously unconscious condition of leader-dependence and of weaning past due. Going beyond insight, the group makes it possible for the patient to have the new experience of actually participating in the shaping of his own social field.

In the work phase a group is able spontaneously to engage in analytical interpretive activities that go beyond the level of giving advice on behavior. This clinical work phase of the group is an essential aspect of interpretive psychotherapy in general. The specific clinical role of the author is described in Chapter 13. Theragnosis is entirely dependent upon the ability of groups to grow into the work phase. Actually, it is difficult, in the case of the author, to distinguish how much his own interest in this phase has influenced his groups. It is possible that temporary identification with the therapist's interest explains why all of his groups engage at every meeting to some extent in the themes 15 and 16.

Observations of other therapists show, however, that even when the therapist is not explicitly oriented toward this process, the group has an interest in, and could easily be reinforced in this interest to analyze how each person in the group affects others emotionally. "Analysis" is a type of communication found in all psychotherapies, and the group setting is no exception to this. For the psychotherapist who believes that the main therapeutic effects come from such cognitive processes as insight restructuring, discrimination, and learning, one might term the work phase the clinician's delight. These cognitive processes of analyzing

interpersonal cause and effect are an essential part of psychotherapy even if they, in the opinion of the writer, are somewhat overemphasized to the exclusion of experiential emotional factors in therapy.

### Factors of Group Dynamics Common to All Phases

Attempting to specify general characteristics of group development which are demonstrable on all seven developmental phases, three common characteristics suggest themselves: (1) basic emotions, (2) values, and (3) quality of verbal communication level.

**1. Basic Emotions.** One can attempt to characterize the relation of each phase to each other phase in terms of characteristic qualities and intensities of emotional manifestations that, so to speak, go with each phase. In this, one could make use of Bion's (1948-51) categorization of basic assumptions or basic emotions that underlie group life in general and could, for example, say that during phases I (initial situation testing), II (leader dependence), and III (familial regressive), the basic assumption of dependency prevails or is stronger than in other phases. In Phase VI (in-group consciousness) emotional anxiety with respect to isolation is strong. Emotional involvement in pairing activities also prevails. In the sixth phase group, members exhibit Bion's (1948-51) "basic emotions" of flight and fight, for in this phase concern with the preservation of the group is acute. In the seventh phase (the work group) members assume that the existence of the group is secured. They can turn, therefore, to emotionally controlled analytic interactions.

From a point of view of intensity of emotional experience, our observations lead us to state that phases III (familial regressive), IV (associative compeering), and V (fantasy and play) contain opportunities for more intensive emotional experiences than do the other phases. For example, when groups enter regressive moods and reactivate earlier traumatic experiences with familial figures with all the hostility and guilt that this entails, one notices stronger emotional experiences in the group members than when they are concerned with who should or should not join the group

(in-group cohesiveness). During Phase IV (associative compeering), members may show very intensive emotional involvement with each other in terms of giving mutual aid. In Phase V the fantasy and play life of the group sometimes reaches an orgasmic intensity of emotional catharsis. The seventh or work group phase is relatively less disturbed by overt, emotionally intensive experiences, although on the latent level new discoveries about the self often arouse anxiety.

**2. Values.** A second possibility for the comparison of phases and for ordering phases to a common denominator presents itself in the idea of a value system, originally emphasized by Allport (1937) and later adopted and expanded by Murray (1951). It might be helpful at this point to give a summary of the scheme of values which Murray very briefly suggests as necessary clues to the action tendencies of individuals. In summarizing this scheme of values which Murray connects with the action tendencies of individuals, we assert that these same values can also be related to the action tendencies of groups, expressed in terms of developmental phases.

The values are these:

1. Body (health)
2. Property (usable objects, money)
3. Knowledge (facts, theories)
4. Beauty (sensory and dramatic patterns)
5. Ideology (system of values)
6. Affiliation (interpersonal relationship)
7. Sex (with reproduction)
8. Succorant object (child to be reared)
9. Authority (power over others)
10. Prestige (reputation)
11. Leader (law-giver)
12. Nuturant object (supporter)
13. Roleship (functional place in group)
14. Group (social system taken as a unit)

As one illustration of how values are combined with different group developmental phases, let us take a value with which most



social psychologists in general and group therapists in particular are concerned—value 13, roleship (functional place in group). A member's concern with his roleship is particularly acute only after he senses himself the existence of a cohesive group, for unless the member experiences the existence of a group, he is not acutely concerned with his place in it. He is more concerned then with value 14, with the group as a social system, with helping create or maintain the whole structure. Concern with roleship is never thrown to the wind, but is very loose during Phase V (fantasy and play), while acutely attended to during Phase VI (in-group consciousness), or Phase II (leader dependence).

Another value of universal interest to all patients in therapy groups is sex, value 7. Sexual, libidinal impulses lie relatively low during phases I (initial situation testing), II (leader dependence), III (familial regression), VI (in-group consciousness), and VII (the work group), while they tend to become very acute during phases IV (associative compeering) and V (fantasy and play) of the group developmental life. The stereotyped cultural value 1, body (health); value 2, property (usable objects, money); value 3, knowledge (facts, theories); value 4, beauty (sensory and dramatic patterns); and value 5, ideology (system of values) are of acute interest during Phase I (initial situation testing), as well as during those parts of Phase VI (in-group consciousness) in which the group concerns itself with a differentiation of its own group culture, its own ideology, from the values prevailing in the macrocommunity.

### The Seven Communication Levels<sup>1</sup>

Seven levels of communication can be distinguished as *progressive deviations from ordinary stereotyped verbal communications*. Stereotyped communications occur in our community generally and are represented by Level 1. Other levels are progressive deviations toward a specific type of nonstereotyped dis-

<sup>1</sup> A discussion of these communication levels was first publicly presented at the University of California at Los Angeles on February 15, 1953 at a program meeting of the Society of Clinical Psychologists in Private Practice.

cussion which is characteristic for the work phase of the therapy group.

The different communication levels are not necessarily "typical" of different phases in the development of the same group. Rather, each of these seven levels may occur in any communication phase, between any two members, in any type of face-to-face group in which free communication of a personal nature is possible. In labeling these levels, we were primarily interested in isolating therapeutic concomitants to each of these communication levels. That is to say, we were interested in isolating the emotional significance to participants on each level, rather than simply clarifying the content of the communications. Perhaps it would be clearer to say that we were interested in the type of communication that occurs in psychegroups (Jennings, 1950), as contrasted to the type of communication that occurs in sociogroups. In sociogroups the communication is concerned with signals to promote cooperative locomotion toward some group goal. This is best exemplified by the communications among members of the same work team engaged in some commercial or industrial process. The function of communication in such work groups, as signaling each other, has the part of facilitating integration of mutuality to produce some material object, some business transaction, or some other gain for the group. Much has been written about this type of communication and the difficulties that arise in symbol signaling.

The necessity of a check system for the correct use of abstractions and symbols has been developed by Korzybski (1951), who speculated that faulty perception of similarities may be due to the fact that such inference is "evaluated as if it were a description, a description as if it were the nonverbal object." Korzybski's approach to semantics has been found helpful by some group and individual psychotherapists. Korzybski highlights the various errors and confusions which occur when the symbol-action relationships become fixated or confused. Indeed, "semantic" difficulties always arise in verbal communication, which necessarily involves abstractions. Inaccurate interpretation of signals is the rule, rather than the exception; consequently, semantics can fill an important place in our culture.

In group therapy the clarification of signal meanings comes up frequently, but here semantics presents a less serious problem than in other types of communication, since in a therapy group any misunderstanding or lack of clarity is immediately subject to further discussion. Group therapy is unlike usual social situations insofar as the sender of a message has the opportunity to make very clear his consciously intended meaning. Any misunderstandings or mistaken meanings by a receiver of the symbols can be corrected immediately.

*Communication Level 1: Stereotyped rational problem-solving.* Stereotyped communications are those which occur in conversations during the cocktail hour and at group meetings where intimate friends can discuss the acute problems they have with other people, especially in family and work contacts. Usually such communications are in the nature of reporting some problem to which there is a response from the audience. Various possible solutions to the problem and ways of improving the acute situation are discussed on a rational basis. Usually considerable loyal reinforcement is given to the sufferer, the reporter of the problem, although criticisms of the conduct which led to the problem are not infrequent. Thus, we have on Level 1 a didactic attitude, which emphasizes in a sympathetic and/or critical mood ways in which human problems can be solved, or avoided, or defended against. Problems are rationally analyzed, a prudent standpoint is attempted, and the irrational aspects of both the statement of the problem, as well as the suggestions for its solution, are repressed and ignored to make room for a cathartic release on the part of everyone participating in Level 1 communications.

Very strange things happen when a presented problem does not appear "rational" to the majority. Then the conversationalists struggle to rephrase the problem until it sounds like a rational one. The participants, in such a case, will supply all kinds of reasons to redefine the problem and to avoid its perception as being irrational. In group therapy, Level 1 shows itself by advice-giving conversations along the lines of "you ought to have," or "you should not have," or "you should or shouldn't." To this level of discussion Henkley and Herman (1951) have applied



the term "oughtness." Level 1 is very typical of brief group psychotherapy in which groups seldom go beyond didactic advice giving.

*Communication Level 2: Nonstereotyped, didactic-directive.* This is the type of discussion that frequently occurs in courtrooms, congressional committees of investigation, or any other small face-to-face group in which the participants feel free to tackle a problem situation with considerable disregard to usual etiquette. When several people feel entitled to pronounce a one-way analysis and judgment of others, we may term the communication personal and directive. Usually, in such communications a definite plan, through which an individual is supposed to learn from the past or profit by in the future, is arrived at. Also, there is considerable criticism and accusation of the patient. In comparison to Level 1, this second level of communication is less stereotyped, less impersonal, often less rational, although equally well rationalized, and of more intensive emotional impact than in Level 1 communications. Level 2 communications require some sort of institutional or group boundary in which this peculiar type of personal, directive-corrective communication is permitted to occur.

Communication levels 1 and 2 have some therapeutic implications. While participating in a therapy group, one's life is still primarily surrounded by a social atmosphere in which communications prevail on levels 1 and 2 only. Participation on Level 2 communications stimulates the self-therapeutic forces inherent in the didactic, educational communications of everyday life. By entering a therapy group, a person participates more in Level 2 communications than he does in the community. What are the therapeutic effects, if any, of such participation?

A freer discussion of the possibilities of problem solutions frequently involves the broadening of a patient's perspective. Correction of misleading narrow information, as in the cases of infertile men who believe this to mean that they are impotent or unmanly, or as in the many cases of antiquated sex-inhibiting attitudes, has an important and definitely useful psychoeducational effect: a shift of perspective on acute problems occurs in the direction of a more accurate gauging of the probabilities of



certain available problem solutions. True, for many the end effect of the realism resulting from Level 2 participation may be a vivid appreciation for the severity of the problem at hand, and the emotional experience of needing expert help to solve the knotty situation. But for others, such broadening initiates immediate experimentation with new and more realistic attitudes and approaches, as, for example, is the case in the majority of patients who participate in the briefer type of group therapy programs.

*Communication Level 3: Cathartic verbalization and play.* Libidinalized communications are most conspicuous and occur repeatedly in psychotherapy groups. By cathartic communication is meant the satisfactions gained through verbal and gestural communication and the play of emotions usually suppressed and repressed in logical, rational communications occurring on the previously mentioned two levels. In other words, talking, playing, and laughing give substitute satisfaction, as well as invoke excitation of usually suppressed interests such as erotogenesis, narcissistic exhibitionism, sadism, hostility, dependence, masochism, flight, fight, and frustration. A wide range of latent needs may find an emotional outlet in cathartic communication. The important point is not only the "release," but also the fact that on this communication level the emotion need not be rationalized as on the first two levels of communication.

Usually, on communication Level 3 there is, parallel with the verbal, a motor pattern of discharge and social action. This is a level of communication which psychoanalysts refer to as the "acting-out" level, which goes hand in hand with a libidinalized, free type of verbalization. However, it is important to note that in therapy groups the extent to which people talk about sex and talk about hostility, about being "mad" or wanting to kill somebody, is infinitely more apparent than the extent to which anyone would go to "act out" any of these motives, which remain dangerous only as long as they remain unrecognized and suppressed. So actually those who have designated the libidinalized cathartic communication as "acting out" are not quite technically correct. It would be more illuminating to say that talk and play is to the act as the bark is to the bite.

Sometimes the discussions have a ferocious flavor, jealousies seem to be alarmingly strong, possessiveness seems to spell nothing but the most alarming indications for the observer of therapy group members interacting on this level. And there usually is quite serious anger at times with those who do not cater to the set-up operations. There is some masochistic exhibitionism and erotic display that may go quite far. But on the whole, the more the therapy group members can freely talk and dramatize these emotions, the safer they are from really doing something about them. Level 3, then, is a definite substitute measure for acting out neurotic motives in society. Since our therapy groups are made up of neurotics, it is natural that this type of communication takes up a great part of the life of the therapy group, although it does not necessarily interfere with more constructive aspects of communication.

The cathartic effect of Level 3 communication is perhaps the most obvious emotional effect observable in group therapy participants. It is most easily observable in spontaneous as well as in clinical play groups of children. Even in the most intensive and advanced adult therapy work groups, libidinalized talk-play is sporadically engaged in. The difference is that an advanced therapy work group is aware of it as they are doing it, while children's groups, less sophisticated adult therapy groups, and cocktail party groups avoid the recognition of what they are doing. In some group therapy programs, such as psychodrama, the communication is deliberately maintained by the therapist on the Level 3 basis. Much has been written by Moreno (1946) and his students on the therapeutic effects of such participation. Particular stress has been laid on the concept of "spontaneity." Participation on Level 3 has been described as "spontaneity training." The reader is referred to the psychodrama school of group therapy for an expert elaboration of this view.

Level 3 communications are highly charged emotionally. More than any other level it involves the total personality, as anyone who has observed young children, engrossed in spontaneous psychodramatic play activities, can see. The concomitant and immediate therapeutic effects of such participation, as cathartic release, regressive relivings, the experiencing of spon-

taneous self-expression and impulse freedom, are enhanced by a shared, orgy-like, mutuality. In the intensive group therapeutic approach, such activities are considered as steps of progression, but not ends in themselves. This step is particularly helpful, as Level 3 communication serves to accumulate life-laboratory data. During Level 3 discussions, patterns emerge that later afford the opportunity for insight into the nature of repetitive fixated gratifications and set-up operations.

In the permissive and enjoyable atmosphere of Level 3 communications, patients experience a relieving escape from the Puritanistic-rationalistic levels 1 and 2 communications of our everyday culture which stresses "self-improvement." Level 3 communications are, therefore, extremely popular with all groups, and the gratifications gained from participating in it cannot be denied. Level 3 is commonly either latently or obviously manifest in all group behavior. Thus, it must reduce important human needs. In our opinion, it reduces by displacement those tensions and anxieties which are instigated and accumulated through participation on the other levels of interpersonal communication. For example, psychogroups are characterized by Level 3 communication, whereas socio- and work-groups are characterized by levels 1 and 2. Participation in the psychogroup releases tension accumulated from participation in the sociogroup. Level 3 participation is an essential phase which permits participation in a deeper clinical effort in other phases of group life. According to Thea Bry (1953, pp. 45-46) acting out "serves as the basis for working through, that is, for the understanding and emotional acceptance of the irrational character of the patient's acts. Acting out serves as a most important raw material for the therapeutic process."

Cathartic playing permits clinical working. Playful acting out provides content for analysis in addition to constituting a tension release mechanism. Whenever groups engage in deep clinical communications on the more advanced levels, there is always some need to "regress" and communicate on a libidinalized, cathartic level. There is a constant fluctuation between realistic learning and new cognitive restructuring, and cathartic, libidinal, tension-reducing routines. Participation in libidinal-



ized talk-play activities also furnishes some experiential data, some content for discrimination learning on the next levels of communication.

When members of therapy groups talk-play on Level 3, they produce interpersonal effects, the repetitive nature of which is relatively observable by all. Under the Level 3 atmosphere there is a free expressiveness which makes possible the demonstration of nonstereotyped effects and hostilities, and these usually take certain directions. For example, those who dominate too much may be passively listened to on the previous levels, but may get laughed at and be made fun of on Level 3. It is on this level that the group often produces a synthesis of the group opinion of a perception concerning a member's personal way of behaving in the group, which the logical and realistic atmosphere of ordinary discussion seems not to permit. In a therapeutically oriented work group, libidinalized play and talk is a necessary condition for the occurrence of communications of more fundamental clinical value.

*Communication Level 4: The testing of interpersonal effects.* People test the group to see what effect they can produce or elicit in the group, i.e., each other. Everybody produces some effect, which is idiosyncratic to each person. Level 4 deals with verbalizations concerning observations made about testing experiences of one's effect on the group. Of special interest to both patients and therapist are recurring and repeated effects, the relatively enduring interpersonal effects, which are noticed by the group. Usually, on this level of communication, the person concerned is passive, while the other persons do the actual discussion and diagnosis of interpersonal effects. Level 4 communication concerns *diagnosis*. It is the kind of perception about people that psychotherapists are trained in.

What is the content of the diagnostic type of communication, this detecting work, on the part of a lay group of patients? There are many ways by which the patients will try to tell their impressions of each other. A factor that facilitates the perception of repeated attitudes on the part of the reacted-to patient is its intensive emotional quality and its repetitive compulsive nature. The fact that Alpha, as a patient, elicits the same type of group



effects with respect to certain interpersonal contexts or situations, becomes clear to nearly everyone. Some neurotic aspect of Alpha's character is discussed by the group.

Once a certain degree of clarity or perception concerning Alpha's enduring patterns of gaining emotional satisfactions from the group has been achieved by the group, the group persistently brings the nature of these patterns to the conscious awareness of the often defensive individual. Indeed, it is remarkable how deeply and unconsciously a defense can blind an individual. A perception of a set-up operation, which for a long time had become obvious to a group and which after repeated examinations of their own projections had been objectively verified by the group's consensus, will often be utterly imperceivable by the person involved. At this point the therapist often helps the group to exercise its patience and tolerance. The patient is always quite surprised at the effect he is told he has on the group. The defense of the autistic belief in one's role, as well as accepting responses to new views of the self on the part of the group-diagnosed individual, are also part of this level of communication, which mediates insight learning. However, this level does not increase actively motivated groping or problem-solving attitudes. Communication Level 4 is comprised of diagnostic communications on the part of the active members and of resisting-accepting curiosity reactions on the part of the subject of the group's diagnostic work.

The therapeutic effects of Level 4 communications can be summarized as follows. Level 4 communications consist largely of reactive observations of repetitively occurring gratifications and social effects. Level 4 communication represents a process of gaining insight into what seems to emerge from the previous levels of communication as a manifest or foreground pattern of repetitively sought and attempted qualities of emotional gratification. Repeatedly disjunctive social effects of behavior are subject to perception and "cueing." Systematic research to determine the exact nature of the therapeutic depth effects of such cueing is badly needed. In its absence, it can only be guessed that the cueing process on Level 4 has a motivational effect in the direction of arousing a "curious annoyance." Anxiety may be

aroused by insight into the repeated manifestation of disjunctive motivations and socially isolating interpersonal effect. This hypothesis may explain why a special culture of the therapy group is required to help the patients overcome their very noticeable resistance to leaving, if only at times, the gratification and the safety enjoyed by participation on Level 3.

The diagnostic spirit vis-à-vis others, the same spirit that propels people to become professional psychologists, is a driving force in the direction of Level 4 communication. That is, all members usually participate in trying to give insight to others. However futile this usually is, the tendency should not be suppressed, for the motivation behind diagnosing and confronting others can, through skillful conducting technique, be turned into the channel of self-observation. This stage of self-observation, once it is entered, is greatly facilitated by the enthusiastically volunteered cueing services of the other members, and it will also be warmly rewarded.

This reward or reinforcement of progression toward deeper and deeper self-understanding takes place in this fashion: the overcoming of resistance makes a patient a more valuable member to the others; his ability to dig honestly and deeply without affected exhibitionism seems to win great silent admiration, and soon such a member feels that the group has accorded him or her a rather secure and respected place. This has an ego-strengthening effect of long-range and transferring significance. Now much depends on how many others in the group can reach Level 4. It is our experience that in a group of eight, unless a majority progresses to this level, no one can go beyond to levels 5 and 6, except very sporadically, and even then only when auxiliary individual meetings are intensified.

Some patients fail to make the transition from the libidinalized play world of levels 2 and 3 into the clinical self-perceptive atmosphere of Level 4. Usually they will terminate their therapy work altogether after six to eight months, during which time such cases frequently have lost their presenting symptoms (such as functional impotence, and phobias). The ego-strengthening process inherent in the free acting out before a permissive au-

thority symbol has already sufficed to reduce or remove the symptom. Those who progress to the fourth communication zone usually stay on to make significant personality changes.

After experiencing Level 4 communications, the patient becomes highly motivated in three directions: First, he would like to change what he sees at once. He regresses under the insight-evoked anxiety of the "you ought," and the "you should" stage, characteristic of levels 1 and 2. Secondly, as the initial regression fails to yield changes, by verbal dictum or intellectualization, the patient will try to change by the very interesting technique of compensation or counterphobic behavior. Now fully realizing and feeling in each group session the disjunctive nature of his living patterns, he tends to experiment with the opposite. In this mood patients are extremely interested in role-playing techniques, only this time their role playing is progressive rather than regressive. They like to try new ways of behaving, new, more efficient, less disjunctive security operations. There is usually no need whatsoever to direct or structure this role experimentation. It occurs within the range of the group life, as when, for example, a previously negativistic-hostile patient begins in his peer-court participations to be friendly, constructive and affectionate.

Some colleagues have cast doubt on the depth of therapeutic gain by this method of counterphobic personality change. This therapist must admit that it does not sound good, theoretically, but in practice many patients have literally gained new ego constellations by long and repeated practice within therapy groups of this dual process: the recognition of the disjunctive pattern and the counterphobic practice of a conjunctive opposite. This practical fact suggests that whatever theory of therapeutic processes we may have, it will have to be modified to account for the very easily-verifiable observation that patients' repeated participation in Level 4 communication will change their security operations with others significantly along more conjunctive lines. As a result of this process, patients whose gratification from interpersonal traffic has been extremely unsatisfactory for years obtain emotional gratifications, which in turn reduce the necessity for



excessive contacts with and excessive demands on others. This in turn opens the way for a fuller development of constructive self-satisfying pursuits of a creative nature.

*Communication Level 5: Contextual associations.* This refers to a level of communication well known to all analytically oriented therapists. It refers to activities in which the group engages in so-called "free" associations. This is to say, they produce material that is not subject to immediately shared perceptions, but rather idiosyncratic associations to such projective items as dreams, drawings, and reminiscences—historical material. A good example is the reporting of dreams which in their manifest content relate feelings about other group members. We have given several examples of such group dreams in the chapter on projective group activities. From a standpoint of interpersonal communication, the dreams of members who in actuality are usually silent are of particular importance. Such patients frequently participate on this associative level of communication. They dream about the group, and through telling their dream can express their interpersonal feelings behind what appears to be the protection of the dream.

One male patient (M-M) who for several months was unable to feel, let alone express, any sexual feelings about the four women in the group, dreamed about these four women coming to the door of his house, and in a party spirit wanting to be let in. He was pleased in the dream and let them into his house. He was surprised, but happily joined the spontaneous party.

This dream report brought a silent member much closer to the life-stream of the group, although he himself did not at first accept the group's interpretation that he unconsciously was attracted to the girls in the group. What brought him closer to the group was that the girls felt that they must be making an impression on this withdrawn male in spite of his overt silence. This incident illustrates how dream-telling is more than just a projective or self-expressive activity, and that, in the group, it has a communicative function. The silent and withdrawn member, who presents to many therapists a technical problem, suffers, according to our theory, from a repression of mutuality and social approach. The dream just quoted is an item demonstrat-



ing the very strong wishes of withdrawn and silent group therapy members to belong and to be close. This wish is frustrated by a neurotic fear of rejection, but in the dream the basic wish breaks through. Dream-telling is a first approximation to perceiving, communicating, and doing something conjunctive about a repressed need for socialization.

On communication Level 5 the group as a whole participates in a chain of association started by one individual. In "going around," each individual contributes to this exchange, which may have started with a dream, or a drawing, or a comment. This group associative product is a very interesting phenomenon, a group projection, examples of which are given in our chapter on projective group activities. The fact already noted that dream analysis in groups reaches a surprisingly deep level of association, although each individual may be interrupted in his own associations, is an example of contextual associative communications. The contribution of each member, which was stimulated by the just previously given association, in turn stimulates the association of another member. Thus, by the time all members have contributed their associations, their quality has become more and more free.

As the Round Robin proceeds, the level of content becomes more and more symbolic. A group association frequently clarifies the very deep and fundamental meaning of a dream, beyond that possible in individual therapy. The communality of dream associations brings up unconscious motivations that would remain inaccessible except in very successful and long-term individual work. It is indeed as if each individual in the group momentarily loses his ego boundary. Repressive forces are momentarily abandoned, social reality has a holiday. This "shared pseudo-psychosis" is one of the most significant aspects of group therapy experience. The holiday from reality evokes material for insight into unconscious motivation. The newly discovered material can be consolidated and integrated later on when the ego's sense of reality is strengthened, as in the working-through aspects of the individual consultation (Federn, 1952).

*Communication Level 6: Self-Perception.* In this more advanced phase, patients verbalize their growing curiosity about

how their personality affects and how they are affected by others. They freely tell the group their own emotional reactions toward each other, without repressing those reactions which are not easily rationalized. They also will freely speculate about the latent motives of their own reactions and about the purposes of their behavior in the group to the extent that they can sense them. This takes the nature of responding deeply to the here-and-now interpersonal situation. On Level 4 the individual heard the diagnoses and interpretations of his interpersonal idiosyncracies which the group has made of him. Also, on Level 4 he has resisted and fought the group. If he overcomes these resistances by gaining some sort of historical perspective (mediated in communication Level 5), if he has learned to use the historical perspective to rationalize and make more acceptable to the self the existence of presently disjunctive behavior patterns, then he will communicate on Level 6, in which the individual becomes still better acquainted with these repetition-compulsions.

The patient will then begin to assume an objective problem-solving attitude, for he has lost many of his previous blind spots and other resistive defenses. On Level 6 the patient's own communications actually facilitate "catching himself" in externalizations of disjunctive motivations. He no longer practices the better use of his mask. He is now willing to take off his heavy armor and to discover the nature of his own body and personality structure. He now gives to the group as many cues as it needs to help him to catch himself, so to speak, in neurotic patterns. Needless to say, this sort of self-perceptive communication is usually a sign of tremendous progress on the part of the patient; it has a good influence on the rest of the group. The relatively relaxed demeanor of such a progressed patient inspires and models for the rest the advantage and safety of being less defensive. It is a level on which the therapist himself can participate and at times share with the group his perceptions about his own person.

Through participation on this level of communication, individuals become more and more aware of their own unconscious goals, tastes, and idiosyncrasies. They also learn of the difficulties, and of all the steps that are involved in fulfilling certain

ambitions. The necessity for modifying basic feelings and desires resulting from the realistic requirement of properly preparing social fields for opportunities for drive reduction are at first startling and "shocking" to the patients who, for so long, have relied on a narcissistically distorted wish-world (Federn, 1952). The painful nature of the discovery that reality means the surrendering of pathological narcissism characterizes this level of communication by fluctuations between progressive and regressive resistant attitudes. On occasions of regressing to the less therapeutic levels of communication, the group is of great help, for it always accepts and keeps alive new attitudes which the individual by himself is afraid to hold. The group has an unconquerable optimism that brings the patient back where he can work again on Level 6.

Along with the shock of perceiving social contact realistically; the patient also discovers a whole host of previously repressed attitudes of affection and warmth and comradeship. He discovers that what he has frequently felt and labeled as hostility is actually a form of anxiety reaction to a fear or frustration, rather than a reaction with a primarily destructive or sadistic intention. Communications on this level also give the patient an appreciation of the power limitations of his or anyone else's individual ego. He senses that group reactions to him frequently are quite outside the range of his own control, in the same way as his own impulses often are. Instead of being frightened, he learns to watch for cues to states of interdependency on groups and on instinct. Instead of using repression, he learns to accept extra-ego forces in the field as well as unconscious forces within the self. He learns to read cues, for example, to his own anxiety about tough spots in life in which he has to "watch himself," and he gets to know where he is likely to become overexcited, or threatened, or fatigued, or easily involved in neurotic externalizations of his own or others. Thus, the patient has the opportunity to perceive some feelings, attitudes, and needs which he did not previously know he had, or which he definitely did not know he had; knowing them, he is now learning to do something about them.

*Communication Level 7: New problem solving.* If, through Level 6 communication, a previously repressed person discovers



actually strong and healthy affectionate motives, he still does not know how to apply them to change their effects on the group. Future progress may now involve jumping back and forth, trying out different emotional responses. Role-playing techniques again come in very handy at this stage of therapeutic progress. The patient senses the need to enlarge his behavior repertoire in certain situations. He experiences the satisfaction of needs which he previously did not know he had. Because patients find change and new learning difficult, some of them regress to Level 5 to dwell further on the historical perspective, for they always find some relief from threats of the imminent future in mentally constructing a chain of historical causation.

Level 7 is reached when the patient becomes interested in finding ways of better managing the newly discovered needs. For a while they will talk out and act out new ways of interpersonal management until they get more and more acquainted with the newly discovered patterns of constructive contact operations. As soon as the patient discovers that he *can* change, that he can learn new ways of creative management, then something exciting happens—the patient loses his defensive sensitivity. He is no longer threatened by making further and deeper discoveries concerning his need system.

The patient is now working creatively on improving methods of relieving himself of these newly discovered excitations in conjunctive ways. An acute learning process on a deep emotional level takes place. There is a tendency to check and countercheck all perceptions and all interpersonal effects. All advanced patients make use of this unique opportunity which communication in group therapy affords. The group, by attempting to understand what the self-perceptions are and what the nature of the resistances and defenses are, frequently attempts to check these meanings by association, clarifying them by references to the self, so that throughout all levels of communication in group therapy a circuitous correcting process is going on. The therapist and the group devotes much attention to keeping the communication circuit functioning.

Communications on levels 5, 6, and 7 likewise have therapeutic implications. For most of the milder neuroses and the



milder forms of character disorders, the conjunctive neurotic patterns yield and change counterphobically during participation on levels 3 and 4. However, in the majority of the more severely engrained neuroses, or the prepsychotic disorders, the disjunctive patterns will persist compulsively, even after the patient has attempted to conquer them by the counterphobic method typical for previous levels. For the more seriously disturbed patients, a culture in the therapy group has to be created and maintained so that the majority can engage in communication on levels 5, 6, and 7. The author does not believe that it is necessary to push everyone undergoing intensive group therapy to these levels. Only when participation on levels 3 and 4 fails to turn the tide is it necessary to provide the patient with an opportunity to participate in a therapy group where most members can and do engage in periods during which they try further to invade the large realm of unconscious motivation.

Through the group's contributions to levels 3 and 4, the nature of which was mostly uncontrollable, the patient is already emotionally convinced of the power of the unconscious. He has seen everyone subject to it, including the therapist. Therefore, curiosity rather than fear is the modal reaction. Having learned to perceive patterns of gratification and of security operation, the patient now takes it for granted that there is much about him that he or anyone else may never see. He has learned that blind spots are not only defense mechanisms of a neurotic nature, but that as Miller (1951) has put it so well, "we always act unconsciously."

In order to understand the therapeutic processes occurring in conjunction with communications on levels 5, 6, and 7, we must realize that we deal with the removal of fixated repetition compulsions, the nature of which is now clear to the patient. For example, a patient with unconscious libidinalized masochism now fully realizes that she "enjoys" pain, that depression, tears, and self-punishment must follow pleasure experiences, and that she sets up the social environment in such a way as to assure experiential repetitions of this tension-reduction sequence: pleasure—punishment, pleasure—punishment . . . Further insight work consists in perceiving more fully the ingenuity of the energy expenditure of the set-up operations that go into maintaining the

neurotic pattern. A deeper appreciation of the compulsion and a greater respect for it may develop. As the compulsive patterns become more and more crystallized, especially in their ego-debilitating nature, the patient becomes intensely annoyed at himself for promoting the very environmental events which he previously used to justify. He begins to understand his neurosis, his nervousness.

Patients are astounded by their discoveries; they truly have the feeling of a changed perspective. With a new perceptual organization there opens up another set of therapeutically important motivations: this time there is no regressive escape—there is a real and highly motivated chase for an “unconscious” cause. As the patient engages in Level 5, he begins to get glimpses of the irrational nature of the motivational forces which to him are not comprehensible. They may be Oedipal fantasies, or incest, or primal scenes, or other fragments from the repressed past life. Some of these will serve as clues to a causal explanation. Simply by emotionally sensing the unconscious forces in distorted fragments and incomplete forms, the person begins to sense himself as a part-aspect of the universe, rather than as the narcissistic center of it. He might learn not only to accept the past as something beyond his control, but also the present and the future as full of forces which determine the range of possible experience far beyond his wish and dream world. By discovering something about his wish and dream world, he may in a true sense gain respect both for the constructive forces present in his environment and respect for the fact that many of his dream thoughts and irrational wishes are constitutional or past-bound. In any case they become something familiar, even if they constitute something which is beyond control.

Now the patient is learning in a still much less formalized way. He learns the sharing of his unconscious. He learns that on the unconscious level man is remarkably confluent, as the group’s dream association work, or multiple drawings clearly demonstrate. Thus, in sharing the symbolism of the unconscious, a symbolism which may have been born in early childhood, or which is constitutionally given, the patient learns to accept the universality of his person, the link-nature of his being; he learns

to accept his interdependence and mutual identification with mankind. Against this background, he may even go so far in therapy as to liken this relatively unpretentious identification with his being to a large extent a blind and unconsciously living creature. He may even gain respect and a positive outlook for the enormous achievement that conscious man has been able to create. He then can trust his unconscious and no longer represses conjunctive tendencies. The discovery of unconscious symbols of conjunctive and mutual motives proves that the neurosis was maintained at the expense of the repression of an object-oriented libido. The now released libido need no longer be used for neurotic disjunctive contact operations, but can be used in a constructive, conjunctive way. Knowing and having faced his own unconscious ways of solving conflict and giving satisfaction, the ego can continue to grow.

## Chapter 17

### RESISTANCE AGAINST GROUP PRESSURE

---

#### Strategies of Resistance

Psychoclinicians are painfully aware that all patients undergoing psychotherapy tend to resist participation in the work process of rehabilitation which they seek and need. The fact that neurotic patients employ resistance strategies against individual psychoanalytic treatment was first observed by Freud (1937). Since then resistance strategies have been recognized as the central problem of all psychotherapeutic approaches. According to Mowrer:

. . . No clinician with even a modicum of awareness of what transpires in the therapeutic situation has failed to sense these strategies; indeed at times he feels all but overwhelmed by them. As data, as phenomena, they are among our most certain and most important. We can fully agree with Freud when he says that "the overcoming of these resistances is the essential work of the analysis, that part of the work which alone assures us that we have achieved something for the patient" . . .<sup>1</sup>

In the group approach resistance also complicates effective therapeutic management as it does in individual therapy. One would expect this from one's understanding of resistance as a symptom of social learning and identification difficulties (cf. Mowrer, 1950). Group therapy quickly and effectively "opens the heart" of the neurotic patient toward his need to learn constructive social contacts. The need to develop natural penchants for innate mutuality also quickly arouses strong resistances against having to make changes. The very efficiency with which

<sup>1</sup> O. Hobart Mowrer, *Learning theory and personality dynamics*, p. 489. Copyright, 1950, by The Ronald Press Company, New York.



the group situation dramatically demonstrates to the patient this necessity for change in self-other social contact operations makes the patient resist the new learning situation. This takes the form of refusing to participate freely in the therapy group. In group therapy the neurotic patient is changed by providing him with an artificially created experience in mastering social contacts. He is forced to experience that of which he is afraid: self-exposure and close group belonging. Group pressure forces him to live by social rules which insure him the immediate emotional and social benefits of belonging. But it would indeed be surprising if the patient failed to resist this process which very directly "goes after" the central problem of his neurotic resistance. Since many co-therapists are involved, the strategies of resistance make use of the whole group situation in ways which we shall now briefly explore.

### Seven Instigators of Defensive Resistance to Group Therapy

**1. Simple Acceptance and Support of the Self "As Is."** As in real life, or in a purely nondirective regime (Rogers, 1951), the patient has in the group the possibility of rationalizing his neurosis as a method for expressing "natural needs." And, indeed, the initial tendency of all patients is toward such a use of the therapy group: to act out the defenses and to seek from the group acceptance, sanction, and approval for the manifest acted-out patterns of personality. In other words, every person entering group therapy seeks to use the group in a supportive way. This is the extent to which group therapy limited to from ten to twenty meetings can go. But in any intensive, continuous program, patients have an opportunity, through the efforts of the therapist and the older patients, to pass from the purely supportive use of the group into analytical phases during which each member learns to examine the nature of his behavior patterns as well as some of the previously unconscious motives behind them.

The patient's wish for help and health is ambivalent. It is not what it sounds like manifestly. It is not a realistic "will to re-

covery" or a manifestation of a healthy "growth force." Rather, the motive behind coming to psychotherapy, like many other major decisions in the patient's life, is a neurotically distorted wish. It is the wish to have all neurotic fantasies satisfied by the magic powers neurotically projected into the "healer."

The patient who seeks psychological treatment actually has no choice but to fight against the very thing he is seeking, because therapy represents an attack on his fantasy life. As soon as the initial "therapeutic honeymoon" (which is maintained by the patient's wish fantasies concerning what the powerful healer will do for him) is destroyed by the therapist's behavior and role, which, of course, cannot and does not support the patient's wish fantasies, the paradoxical resistance-fight is on. The "paradox" is understandable if we see that it is only an apparent one. The patient *apparently* comes to be cured. Actually, the patient does not come to be changed; *he comes to be approved "as is."* He comes to have his neurotic defense mechanism provided with the stamp of tacit or actual sanction on the part of the "group-mother" and the authority figure of "the doctor of mental health." Unconsciously, the patient hopes that by winning the therapist's approval, the infantile conflict over feeling unloved, left out, dethroned, or rejected, will be miraculously repaired.

There is in every new patient a magical faith that the therapist's and the group's acceptance and attention will make up for all the lack of love and protection, and the lack of self-confidence. Patients show remarkable ingenuity in maintaining this illusion and in some schools of psychotherapy the clinicians reinforce it. After all, repeated visits have proved to the patient that the therapist "accepts." The experience of not being destroyed by the magic healer but of being "accepted," the experience of not being thrown out by the group but becoming a member—therein lies the proof that one is, after all, acceptable "as is."

This initial gratification and relief in response to the therapist's and the group's acceptance is not altogether ineffectual. Realistically, it carries the new patient into a feeling of cohesiveness with the group which is essential for later, deeper therapeutic work. The initial gratification obtained by the patient during

the "acceptance-as-is" phase can be likened to the great relief of a crew lost at sea when finally rescue arrives. This initial relief of finding some accepting help is associated with the person of the therapist, and the new relationship to him now is enjoyed. The maintenance of rapport becomes a new motive, strengthened by the conservative-preservative tendencies of a traumatized organism (Goldstein, 1939).

When the motive to cement the new relationships to the therapist and/or other group members is strong, the new patient will tend to remain with the group even after the "honeymoon" is over. He does so in order to master the object-relationships which have already stimulated and challenged his contact needs. In the group method the "therapeutic honeymoon" is used not only to establish one initial object-relation to the therapist but also to launch at least one or two other relationships to other most-liked members of the therapy group.

**2. Threatening Self-Insight and Ego Limits.** Disappointment, shock, and even "trauma" is a response to the discovery that the group demands: "analyze yourself!" This requirement to change one's orientation toward the neurosis and to give up displacement and other defenses always initiates major resistance. For initially every patient, as we have noted before, seeks approval for the self "as is." In the group method the intensity of the switch from the "accept me as is" outlook to "I have to get familiar with my neurosis" is cushioned and made easier for the patients because of the possibility for identifying with older patients.

But even after the patient has shown willingness to make an analytical as well as supportive use of the group, resistance of another type comes up, which is a result of having given up the resistance of flight through acting out. This new resistance is the same as that encountered during intensive individual analysis: there is a depressing aftereffect which follows the patient's recognition of his own neurotic behavior patterns and motivations. In group therapy an important factor which helps the threatened patient to overcome this new resistance is the acceptance and support of the group.

But groups may get depressed and discouraged when a member, after having been repeatedly "shown" to possess some neurotic and disjunctive thought and/or behavior pattern, continues to resist either "seeing the light," and/or refuses to show interest in changing. Persistently defensive members are in a clear sense nonconformists, since they do not yield to majority group consensus on "what is wrong" with them. They are both a strong threat to the group unity as well as strongly threatened by the group. They make group management difficult, since they naturally tend to function as leader-initiators of anticlinical and anti-theragnostic "movements" toward evasive group activities. Threat, frustration, and resistance lead to hostility.

With the acceptance by and support of the group the individual patient can release hostility against the therapist, who is correctly perceived as spearheading the analytic work of the group which resulted in painful insights. Since in the group approach the transference relationship of patient to therapist is only one among many vehicles of the theragnostic process, the cathartic hostility release toward the therapist rarely destroys the effectiveness of the therapist's influence. For the therapist's influence in the group approach reaches the patient primarily through group pressures, not directly through the therapist's interpretation. The therapist's skill in perceiving, communicating, reflecting and summarizing neurotic behavior patterns of the group or the individual puts him in the position of the main gatekeeper for interpreting analytical material. He is the communicator of group consensus as he sees it.

Since the therapist does not demand followership for his perceptions and, of course, fails to "punish" those who do not go along with him, the group soon develops a self-protecting defense ritual: it considers any contribution by the therapist meaningful only when sanctioned by group consensus. Only when a majority of the members can say "touché" to the therapist's messages does the receiver of them feel obliged to consider them seriously and to react to them. Depending on the sensitivity of the therapist for being aware of hidden group feelings, and depending on the "depth" of his contributions, the group may sanc-



tion his contributions more or less frequently. We should like to examine what happens when the group does sanction a relatively "deep" perception of an unconscious process in either the group or the individual.

This is the situation, say, when on the heels of a therapist's summary of the group's dream association, he brings out that the associations showed a fear of women (castration anxiety). Then the united group majority may try to "convince" the dreamer of the appropriateness of this interpretation. In this attempt to convince an individual patient, the group will bring to bear all kinds of other instances corroborating the evidence of the fear of women, within the group and outside the group. Therapeutic progress is made through the process by which an individual patient accepts repeated group consensus concerning him. In fact, it is the unique advantage of group psychotherapy that constructive interpretations carefully and sparingly introduced by the group therapist may be accepted with less resistance because of group sanction and consensus.

Now let us turn to the many instances in which, without the therapist making any contribution at all, a group consensus forms with respect to a member's behavior or problem. In this case, the therapist may or may not agree with the group consensus and thus give it expert sanctioning. This interplay in the sanctioning process between therapist and group leaves the patient with a variety of opportunities to express his resistance.

Resistance against group consensus, whether leader-sanctioned or not, is a tension-arousing situation because of the relative intolerance of face-to-face groups for deviant, nonconforming reactions to majority interests. The exposure and confrontation of disjunctive and neurotic mechanisms and behavior patterns is anxiety-evoking for the object of such analyses, while for the exponents, the analytic process affords tension release (cf. discussion of advice-giving). Forming majority consensus interpretations reinforces the cohesiveness of the group and releases unconscious threats concerning disintegration of the group. Because of these two pro-analytic forces, (1) personal need reduction and (2) group cohesion and conformity, there is usually a

fairly free flow of theragnostic group work with tension residing primarily only in the one individual who at the time is the object of the group's analytic work.

Patients are not trained psychotherapists and they thus have to learn from their own group experiences to practice the professional dictum to refrain from "pushing" insight material beyond the ego's capacity to integrate it. New groups may become too enthusiastic and, as a result, jar or even traumatize some patients. Such ongoings result not only in strong defensive resistance (which sometimes includes leaving the group) on the part of the affected individual, but the group as a whole also has a tense and depressed sequela, possibly because of a sense of guilt and fear over having been "too tough," or too authoritative. While it does not take groups too long to learn how not to go beyond the capacity of the ego, they are not infrequently "fooled" in their gauging of ego strength, especially in those patients who use the compensatory, "I am adequate" type of social defense. Here the group makes constructive use of the therapist's technical knowledge concerning ego defense dynamics. Nevertheless, "premature," anxiety-evoking exposures occur often enough to contribute their share of group tensions and instigation of resistance against clinical work. The therapist's discussion before the group of his understanding of such ongoing tensions and their management seems to help relieve the tension. Helping the group sense ego limits in their own members' capacity to absorb or integrate the group's analytic work has been found to be a therapeutically effective technique.

**3. Character Disorder: Resistance to Group Life as a Way of Life.** Some character disorders have a style of life, the essence of which is resistance. There are certain patients who act out without ever looking at themselves and their neurotic ways of manipulating others. These patients are not likely to give up their neurotic satisfactions as a result of pressure from "a bunch of nuts" (the group). These character disorders are symbolized in the hard language of Alfred Adler (1946) as the "pampered only child who was never dethroned." Such "pampered" patients, previous to group therapy participation, have usually had no effective experience with adjusting on a coopera-

tive, compeer basis to other members of the same in-group. For them, group therapy is productive only when they are placed in a very mature and advanced group, for they will test the acceptance, patience, and tension of new, insecure groups to the breaking point. These types of patients are frequently the object of hostile tension releases on the part of groups. Management of such patients involves intensive individual therapy contact, concomitant with the group experience. Consecutive placement of such a patient in different groups until he senses his resistive "style of life" has been tried with little success (cf. discussion of "The Monopolists" in Chapter 2).

**4. Resistance and Role Fit.** We have made a study of thirty-two "drop-outs" over the last five years and have come to the conclusion that the primary factor for a patient's having to leave or wanting to leave a group is not to be found in his personality structure, but in the nature of his role in the group. The most obvious evidence for this conclusion comes from the fact (also observed by Wolf, 1949-1950) that certain patients who have the most intensive conflict in one group find it relatively easy to communicate and participate in another group without any remarkable therapeutic effects having taken place in the switch. It is possible that the act of leaving a group in itself changes the motivational structure of the personality to adjust in a new group, for example, as a manifestation of rejection for a hostile act, or a compensation for a rejection. Most helpful for an understanding of the "drop-outs" is the concept of the *gap* or role fit in a communication matrix. In each of the thirty-two "drop-out" cases, we could identify a condition in the group life which may be expressed as an intolerance for the manifest acting out needs of the patient.

For example, a male patient, who later found very good adjustment in another group, did not fit in the first group. He refused to play the role that the group had room for, namely, a dominant, aggressive role. He could not fill this role gap. He could play only "the baby" role and he demanded a great deal of attention and guidance, which the group gave reluctantly. He insisted on being included in every activity, but in this particular group the cliques were well formed and he wasn't socially or



sexually attractive enough to be included. This eventually made him very aggressive against the group, with its disruption as a major purpose. He warned the therapist before his last meeting that, "I will convince all of them of the futility of group therapy and will take them along with me to dianetics." What is important about this case is that certain groups cannot tolerate too many demands. In another case, a patient left because he played too much of the therapist's role. This was his preferred defense, but the group did not want to have more than one official clinician, and much hostility from the group caused this patient to leave. It is uncanny how a group which feels a member to be "surplus" or distracting behaves in either a very hostile-rejecting and/or completely ignoring manner toward individuals who become isolates because they fail to fill the role that a given group has to offer.

Another example of a "drop-out" case is that of a twenty-four-year-old secretary who after apparently making a good group adjustment began to interfere with the group's need for free discussion of sexual material by expressing excessive and strong prudery. At one time she told the group, which tended to interpret her reaction as enviousness of their relative freedom: "I'm really upset by what I hear, not merely envious. I'm upset. Here you are and you're supposed to be my friends and you have done such a thing, such dirty business. The way you talk about it, sex is a dirty business, and I can't see how you can help me get over my attitudes." This patient was obviously very threatened by the discussion of sexual material in a mixed group. Her prudery was not tolerated because this group already had the role of "the moralist" filled. A prudish person fulfills a sort of super-ego function in a group provided she or he can accept this role, as we have noted in the case of a fifty-four-year-old high school principal, the son of a minister, with paranoid feelings concerning his wife's infidelity. That man was also shocked by the free discussion of sex in his group, but unlike the secretary, his group accepted his prude role and he himself was quite proud of it. He had a very stimulating effect on the group, as he evoked very intensive authority reactions. *Resistance is related to the role repertoire of a group.* In the above example, the secretary's ther-



apy would have taken a much less resistive course if the group had had an "opening" for a "moralist."

#### 5. Resistance Due to Adequate Roles in Social Reality.

The majority of patients undergoing group psychotherapy in the writer's private practice belong, as in the two sample groups, to the middle and/or upper range of the economic, social and educational class structure of a large urban community. In such a sample, the majority have very adequate, often highly "successful" social positions. They have polished skills in social role-taking, as long as contacts are not too intimate. Our patients are not "isolates" who come to the group to overcome their "sense of social isolation," and they are not "socially crippled" in any obvious sense. If the "social hunger" theory of motivation for group therapy participation were valid, these patients would never come at all. They know their social roles well enough to get along successfully in society. They constantly work with and in groups in which they often hold leading positions. But they are unhappy "inside" and usually also unsuccessful in building and maintaining intimate reciprocal interpersonal relationships, such as those demanded in marriage, family life, close friendships, and co-working partnerships.

A hysteric patient who is happy "except for my symptoms" also often exhibits smooth social adjustment, as in the case of business executives and scientists with peptic ulcers. Most of these socially adequate patients invoke hostility and attack from the group because of their tendency to use "their smooth social front" to pretend deep participation, when actually they just coast along on their higher social status. Their communications in the group look like participation, but eventually the group senses the peripheral nature of the ego involvement. Then the group will try to "go after" such a patient until he drops his veneer and communicates his inner problems more fully.

The social front as a form of resistance is very effective and often decides whether or not psychotherapy may succeed in changing the personality of the patient. The extent of the secondary gains obtained from an ingrained defense system of smooth social behavior is very great. Let us take the example of a successful Hollywood actress in which the exhibitionistic defense

against her own sexual drives led the attractive patient into a successful movie and television career. The force behind her full-blooded exhibitionism is the well known displacement of her anxiety over sexual attractiveness and her conscious fear of sexual rejection. But in view of the fact that this method of displacement carried with it considerable gain in economic and status lines, the approach to her problems was complicated, especially since her therapy group tended to enjoy her "as is," rather than work on her "interesting" defenses.

Actors and other artists often mention in early interviews their fear that psychotherapy will remove their "talent" for exhibitionistic self-expressions. While such fears are understandable from a primitive point of view, they are not well founded because of the fact that the exhibitionistic defense has been of long standing and has developed secondary drive value, or autonomy. Such patients can be safely assured that their ability to play the exhibitionistic role in circumstances appropriate for it will not be handicapped or lost because the expressive habit has already become an autonomous part of their personality.

What is true of actors is also true of the neurotic successful business and professional man, who often is "rewarded" (financially) for his, let us say, Oedipal hostilities to his business associates and competitors. Hostilities are released in such terms as aggressive, managerial leadership, go-getting sales drive, or the building up of an "enormous practice," and fame. When for personal or medical reasons, such patients must come to group therapy, they soon find themselves attacked by the group for being too defensive. Individual patients who are able to perform adequately, or even in a superior manner, complex professional roles in the real macrocommunity tend to resent deeply and resist the therapy group's critical attention to their inadequacies in intimate, interpersonal relations. Such patients' very survival depends on their ability to make a "good impression" in social situations. Being unable to get past a perceptively keen therapy group is indeed a new and frightening experience to the many psychosomatically suffering patients who perform well in the macrocommunity. Therapeutic management here must include regular individual contact during which the patient can be helped

to examine with a calmer perspective the effects he has on the emotions of the group.

**6. Resistance and Tension Resulting from Inability of a Group to Have Influence on a Member.** Since the group's goal is to influence individuals in the direction of changing personality patterns, any sign that the group's interpretive suggestions are useless, meaningless, or irrelevant to a particular member increases tension. The following protocol from Group II is a brief excerpt from a long process during which this group struggled with the problem of one patient (U-F) who so wanted only support and acceptance for her defenses that she resisted analysis of unconscious motives and gratifications.

PROTOCOL NO. 16: GROUP REACTION TO A  
RESISTANT NARCISSIST

[Mixed group, four female and four male adults. Four hundred thirtieth meeting for old nucleus, fourth meeting for newcomer, M-F. During the first hour dreams were told and interpreted, then after a lull, the "left-over" minority addressed himself to the group.]

R-M: I have something to tell you that none of you noticed at the last post-session. I think U-F is jealous of my attention to M-F, our new member.

[Several in the group concurred with the observation that U-F is very jealous when other members obtain more attention. Then the group asked U-F, a very shallow, neurotic, narcissist, if she concurred with the group opinion that she feels jealous. She denied it. The group then discussed this patient's expectation of attention and service from everybody without reciprocal "giving."]

L-M: You know, U-F, you have been with us now for many months and you have made it quite clear that you do not like any of us in the group and you are critical of everything the group does. You go as far as diverting the attention of the members, even when they are working on something involved and important to them, such as when I tried to get the reaction of the group to my homosexual dream last week, the dream that frightened me, and in the middle of everyone giving me some interpretations

and cues, you yawn and ask, "Are we going to that horrible restaurant again after the meeting? I don't like the food there." You diverted the group from its work, you had no respect for what we were trying to do, and your interruption contained a criticism of a place which the group has learned to like and accept as a post-session meeting place. Are you surprised that you are all alone in the group?

U-F: I know I am alone. I don't care. How can one get involved with anybody whom one meets only twice a week? I have nothing in common with any of you. I am considered very popular and "warm" outside of here, I assure you.

T-M: Putting herself apart is, I think, a great defense. It's a way of feeling superior, instead of perceiving that she is alone.

L-M: I don't care whether or not she puts herself apart from the group. What I care about is that she gave us hell last week for not calling her and inquiring about her brother's illness. In other words, while she assumes the privilege of disrupting and disliking everybody, she expects to receive the privilege of being attended to in a warm and courteous way.

K-F: That's just like a narcissistic princess—the kind I wish I could be. Everybody holds himself in readiness in case I need them, but you—the princess, I mean—never does anything, and by her mere presence demands attention and cooperation.

[U-F starts to show tears. P-M immediately perks up. Group laughter.]

P-M: The group is amused. I am actually blushing. I was caught with my pants down. You sure are right. I am fascinated when somebody breaks down. I really must love it. I am blushing. I am ashamed of it.

Therapist: It's possibly true that he gets something out of others' suffering, but in this case U-F's tears are probably all to the better. It shows that she can get emotionally involved with the group, that she actually is not indifferent to you all.

[U-F, who during the last words has really started to show tears, now is sobbing. There is a pause in which anxiety, possibly guilt over having "given it straight" to U-F, is apparent; then a patient offers a face-saving interpretation. He provides a defense, the interpretation having no actual dynamic significance. Here it comes from the same patient who felt badly about enjoying her suffering.]



Th.: I think I should defend P-M here a little bit.

P-M: Oh, I wish you could.

P-M (to U-F): Do you like routine?

U-F (has regained her composure): No, I hate it.

P-M: I thought so. When you were sick for so many years, as a young girl, you were subjected to a rigorous medical routine, exercises, and the like.

U-F: Sure, and diets and nurses. Sure.

P-M: No wonder you don't like the routine of group therapy and going to the same place—the same faces, the same stupid problems.

[The group is slightly ironical, but does not wish to upset U-F further.]

U-F (buys this opportunity to "admit" something): Yes, I accept that. I don't like routines. I like that. That's touché.

[The topic of U-F is completed. There is a lull.]

O-F: Let's get back to R-M and M-F. I noticed that you talked quite a bit to each other. I think, R-M, you have found a new friend, whether U-F is jealous or not.

This discussion reflects the kind of hostile tension that narcissistic members who cannot develop a personal liking for any other member generate. Tension arises from the fact that such a patient so stubbornly resists group influence that the group has no choice but to yield to the defenses of the patient. Such a tension situation cannot persist very long. Among the many ways that it can be resolved is for the resistive isolate to leave the group, as happened in this case.

**7. Individual Resistance to Majority Pressure.** As we see it, the dynamics of the relationship between group pressure and individual reaction involves three steps: (1) Group perception is always ahead of individual perception in terms of depth of insight, ability to integrate, finding appropriate labels of communication, and the like; (2) the individual under discussion always trails behind as a manifestation of ego-protective and defensive processes; (3) both individual and the group reflect in terms of many signs of tension and anxiety that everyone's frustration tolerance is tested by the sensing of a gap between individual and group perception.

For the "trailing" individual the anxiety and frustration is instigated by the unconscious fear of isolation. This fear may, upon sensing a trailing position, express itself in terms of "resistance." Such resistances, however, may actually mean that the patient is psychologically lowering the intensity of his feelings of belonging to the group as a psychological method of defense against the pressure of the group to conform to its perceptions. Naturally, such a pressure would be of minor consequence if the patient's feelings of cohesiveness and group belongingness were less intense. The group's recognition that a serious gap exists between majority perception of inner dynamics, such as the meaning of a dream, and the individual's readiness to accept the group's perceptions instigates group tension as a function of the unconscious fear of the group concerning its own disintegration. Now the group as a whole resists the psychotherapeutic process. Again we can understand this kind of resistance as a form of reducing unconscious fears of disintegration which may have been stimulated by the group's own analytic work on its individuals, for, by definition, the group is always ahead of the individual. Thus, the very essence of the analytic, verbal communication process occurring in group therapy, ipso facto, produces resistance tension. Group therapy participation is not effective for the elicitation of therapeutically helpful insight into unconscious motivational dynamics without the instigation of group tension and resistance against that very process, a fact which must be kept in mind.

A fuller recognition of the dynamic interplay between group pressure and individual defense should include a respect for individual differences in speed of insight formation and integration, as well as a recognition of the general difference in speed of "seeing" between the slow, defensive individual and the alert, enthusiastic, and highly motivated group. It is the recognition of these group dynamics which permits the derivation of specific clinical techniques suitable for the group medium, such as the sitting-in technique described above. Unfortunately, at the present time, research into these dynamics is only in the beginning stages.

**8. The Sitting-in Technique.** Therapy groups often attempt by direct pressure to change the defenses and resistances of the patient. A study of the effects of concentrated group pressures have resulted in suggesting a technique which we have lately been using as a way of easing the resistance-producing effect of group pressure. We have called this technique the *sitting-in* technique, by which we mean that in the group's pressure and diagnostic work concerning any one individual, the analyzing majority does not address or seek confirmation from the analyzed patient directly or immediately. Rather, the patients address their remarks to each other, as in a staff conference, with the affected patient sitting-in on the discussion and being free to acknowledge or comment, or to refrain from any participation, depending on his readiness to become overly involved in the group's analysis.

We introduce the "sitting-in technique" by sharing with patients the results of our follow-up studies of premature "drop-outs," which we found consisted largely of patients who had become extremely defensive after repeated, overt group pressures on their defensive behavior. Not all the author's groups took this suggestion, for it apparently removes some of the sadistic and other unconscious gratifications entailed in advising, guiding, and influencing others by directive methods. Also, while the older "hot-seat technique" was responsible for the instigation of strong overt resistance, it also provided all participants with an immediate neurotic sadomasochistic gratification. Being on the "hot seat" gave masochistic gratification to the advisee, and creating and maintaining the "hot-seat" pressure gave fairly obvious sadistic gratification to the "analysts." In contrast, the sitting-in technique does not afford these same neurotic gratifications. Accordingly, older groups who have already tested the neurotic gratifications inherent in the "hot-seat" technique were somewhat loathe to shift to the newer sitting-in technique. However, consistent interpretation on the part of the therapist of the resistance against growing from the more primitive to the more mature group pattern eventually succeeded in bringing about the shift in all groups.

The sitting-in technique is now used in the majority of the analytic work patterns of our groups, regardless of whether or not the particular member analyzed is defensive or receptive. In dream association work, our groups now do their associating with little regard to the presence of the producer of the original dream. By "sitting-in," the latter, in turn, is by no means passive. On the contrary, the fact that he knows that he need not respond to and that he need not defend himself against the ongoing group discussion concerning his dream enables him to "sit back" more relaxed and recall associations with the things that he is hearing about his dream or behavior.

The *raison d'être* of the sitting-in technique, however, goes beyond considerations of resistance. We noticed that the pattern of communication in the "hot-seat" technique favors pairing pressure, that is, spoke-like channels of communication. In contrast, the sitting-in situation produces a communication network which is less compartmentalized. Instead of every individual member's talking to the one member on the "hot-seat," the majority can discuss in a free give-and-take their impressions with each other. This type of communication network, characteristic for the sitting-in technique, favors the formation of group consensus. The former spoke-like pattern impeded the formation of majority group consensus. Since the formation of group consensus is vitally important for establishing social reality, we were happy to find that the sitting-in technique greatly facilitates a quicker and fuller development of majority group consensus in the analytic work (theragnosis). The sitting-in type of discussion has no two-person subgroup compartmentalization. There is no division between the listening audience and two actively performing communicators: the one individual whose problems are discussed and the discussant. In the sitting-in situation all parties contribute their associations to the discussion in a freer manner for the purpose of forming a group-perception.

The use of the sitting-in technique reduces the frequency and intensity of those tensions which arise inevitably from the dynamic relationship between the pressure of the majority of the group and an individual recipient of that pressure.



## Differentiation of "Resistance" from Neurotic Anger

Often the most characteristic symptom of group tension is an air of hostility that may linger over an entire session. There are many sources of anger in the group, but there are two frustrating sources, basic to and inherent in the group therapeutic process. These are, first, that the other people in the group "do not behave right," that they do not play their roles as demanded by the fantasy life; and secondly, that everything is subject to analysis. The first source of anger stems mainly from compeers and, therefore, the hostility is directed toward them. The second source usually stems from the professional, clinical influence of the therapist and his function in the group, and that aspect of the anger is conducive to hostility directed against him.

Patients in groups interact on a reciprocal principle which is in the direction of conserving output but expanding the intake (of gratification). It is as if a minimal exposure prevails by which each person tries to get as much tension release from the other with as little self-exposure as is necessary to get maximal reciprocation of the kind needed. We would like to know what people seek in each other and set each other up for. It seems here that it is useful to postulate the search for a dovetailing "fit." A "fit" is that personality configuration or role which is suitable to acting out a set-up maneuver.

Freud (1922a) and Adler (1946) noticed that every inner tension needs a personal object, counterpart, or social object to work the inner tension out on. This search for the fitting personality, the personality that "clicks" or dovetails with our inner needs is a basic force operating in the direction of mutual and reciprocal interaction. However, it is also a force toward inner personal tension, hostility, and anger. The process of finding to what degree another person will or will not fit is very complex and frustrating. It may cause the searcher to behave in ways which, under certain circumstances, involve his going against his core personality. Often group members "bait" another person to trigger him into action, just to see how the other person reacts

in order to gain some impression from a variety of situations concerning whether or not the core of that *other* person is such that a fit is possible.

The author is certain that this process is very rarely a conscious one in all its aspects. Certainly the experimental maneuvers which individuals set up for the testing of others' fitness are hardly deliberate, for all they are very ingenious and skillful; deliberate and conscious social interactions are usually quite obvious and clumsy in comparison to those unconsciously governed. That such maneuvers exist is evident from the fact that they can be made conscious through intensive group therapy in a way that has little to do with suggestion or indoctrination. The author never discusses these concepts with his patients. This is not done via an intellectual process. Rather, "neurotic anger" is the vehicle. All the therapist needs to do is to ask the group to explain the reasons behind the here-and-now flare-up of anger between two or more patients, and they will themselves eventually bring out in rather slow, anecdotal, and clumsy ways the very factors which have been summarized here.

As soon as one person subjectively believes another person's personality "to fit," then he is ready to show a tendency to cement the relationship, a tendency to secure the other "fitting" person, for the time being, as a quasi-permanent member of his social communication network. At this point the neurotic personality again makes many "mistakes." He lets his selection of fits and misfits be governed by his defenses and his overanxious needs and wishes, rather than evaluating the reality of the situation more carefully. For example, dependent, neurotically fearful adults, or an ego-vulnerable child, often show a counterphobic love of aggressive-hostile personalities when actually their emotional needs for affection are unfulfilled.

From a realistic mental hygiene point of view, such persons should want to stay away from people with hostile, aggressive, rejecting personality cores. But as the frequency of sadomasochistic alliances demonstrates, the defense of identification (with the source of danger) may blind a person against a realistic appraisal of his own needs for love rather than hate. To the neurotic's misperception of his own need of what would be growth-

enhancing there is added a second set of errors resulting from the incompleted or undeveloped level of social skills in communication and cementing of intimate relationships, an aspect of neurosis which has been described in detail by Cameron and Magaret (1951).

In combination, these two "mistakes" breed frustration, discontent, and hostility; for even if the neurotic has good social skills, as many character disorders have, they attract and work on the "misfit," the wrong person (wrong for their own true needs), which leads to a lack of satisfaction within and anger toward "the fit." In the more severe neuroses and in the psychoses, anger is further intensified by the unrealistic and fantastic demands that such patients unconsciously make on their potential set-up partners. When such unconscious "demands" are acted out in the group in the form of trying to influence one or more persons to act and behave in certain loving or hating or other ways, and when no one actually can act according to the "pseudo community" demanded by the neurotic fantasy, then interpersonal anger outbursts occur.

Anything that interferes with the opportunity to act out the fantasy wishes and fears is a frustration which is reacted to like any frustration, not only with aggression and anger but with a host of other adjustment mechanisms. Much of the insight gained by psychoanalysts and other individual therapists into the psychological nature of resistance can be applied to the group therapy situation also, except that in the group, the patient can make his individual responses anonymously, i.e., as a part of a group response (Bion, 1948-51). The opportunity anonymously to give "free" emotional expression "tricks" the patient into revealing his handicaps. As soon as he is tricked by the seductive environment of the group therapy atmosphere, there appears the uninvited guest of analytic insight, and of the need for change. It is as if somehow mankind's dream of flying like a bird becomes momentarily a reality and with it, suddenly, the uninvited anxiety of being lost in flight. An unsuccessful take-off and crash landing follows.

All this is symbolized in one simple operation: the asking of a question which, initially, is never asked by anyone but the

therapist, and which only gradually and reluctantly becomes part of the culture of the therapy group. The question is: "What within yourself makes you tell or be aware of this or that advice, this or that interpretation? What is the 'meaning' of this action? What is the fantasy that you wish to bring to realistic consummation?" For in the group the patient is encouraged to act spontaneously, that is, upon first impulse. Then, when confronted with social reality, he may not be able to rationalize the impulsive, spontaneous behavior satisfactorily. This is the unrationalized part of the self. Now the patient discovers the nature of his neurosis, and much depends on whether the ego is strong enough to continue the work. If not, the patient may leave, or may counterphobically "cure" himself quickly. This process of reorientation is not smooth, but is filled with frustrations and hostility.



## PART III

---

### FACTORS OF GROUP DYNAMICS IN THE THERAPEUTIC PROCESSES



## Chapter 18

### MODELS AND CONCEPTS OF GROUP LIFE

---

#### The Group as an Agent for Primitivation of the Rational Individual

The nineteenth century concept of group life, developed by LeBon, stressed the group's influence on the individual in the direction of dependency, conformity, irrationality, and suggestibility. In popular thinking the group still is seen as an antithesis to the rational independent individual. Under the group's influence a creative and responsible person is supposed to become just one of the mob, an utter bore, subject to the hypnotic influence of leaders and/or the "mob mind." This early formulation of psychological interdependence between the individual and the group, to which Freud (1922*a*) subscribed, was based on observations of the behavior of loosely organized mobs. Mobs are formed by separate individuals in order to lose their independence, and to release, anonymously, certain primitive emotional needs, such as dependence on a leader figure or symbol.

The theory that individuals tend to seek a group in order to release unconscious emotional needs *anonymously* represents a contemporary version of LeBon's original theory that groups make individuals express "primitive emotions" (Bion, 1948-51). During the age of enlightened rationality the group was the seductive villain who made the good and responsible individual into a decorticated subject, seeking only such thalamic satisfactions as the mob mind, guided by leader direction, could offer. During the age of psychoanalysis the individual became the villain who tried to seek, through group participation, some release of unconscious and primitive impulses, anonymously, that is,

without loading his individual ego with responsibility for such expressions of basic emotions.

Lewin (1951) noted that the concept of "group" has "a somewhat chaotic history" which to this day "seems interwoven with philosophical and metaphysical considerations." The muddled thinking about the concept "group" is, in the author's opinion, symptomatic of a strong emotional and mostly irrational fear that the herd might trample down man's precious individuality. Man, rationality loving, fears that which he does not know or that which he is unable to control, especially when the unknown force has to some extent the power of control or influence over him. It is the *fear of the dissolution of the individual* which we encountered in our discussion of the interdependent nature of personality. The rejection of the idea of group-emotional influences on the individual may be occasioned by the same repression that denies the influence of the unconscious. In the practice of group psychotherapy, we meet many neurotic individuals imbued with an unconscious anxiety or conscious fear that, in group belonging, they may lose their individuality. Such a neurotic reaction is detectable when individual patients are first confronted with the idea of group psychotherapy. From the viewpoint of clinical dynamics, this attitude is largely a symptom of the ego defense of the individual, which attempts to rationalize the neurotically disturbed person's inability to feel a sense of belonging and to be a participating part of any constructive group.

The neurotic patient's fear of the group as destructive of the individual is a neurotic fear. If it were a realistic one, the whole approach to psychotherapy through the group medium would be self-contradictory. Realistically, individuality is enhanced, expanded, and creativity stimulated rather than being dissolved and restricted by the individual's participating more fully and becoming aware of social forces. The fullest development of the individual personality requires awareness of the social forces which, while they may not shape every detail of the person's thinking and feeling, do define the range of his choices and the limits to his freedom of locomotion as an individual. True individuality and true creativity are possible only when the individual is capable



of creating for himself a social field of interaction and belonging through which he can fulfill his needs discriminately.

### **Group Primitivation (Retrogression) and Reactivation**

We have seen that all patients during their countertransferences and neurotic dovetailing reactions to each others' dependency needs will at times act in a directive, or "parental," manner. In doing so, they play into the hands of that minority of the neurotic patient population who have experienced severe psychological trauma in their original family group from directive-sadistic parental countertransference to their natural dependent state as children. The continuous occurrence of advice giving and of other directive-critical stimulations volunteered especially by the newer patients themselves, for each other's benefit, naturally brings about a certain primitivation, or what Lewin (1951) called retrogression under conditions of frustration.

During these primitive emotional atmospheres, characterized by directive "pressuring" between patients, many patients "let go" of long suppressed hostile and libidinal emotions. When the patient "catches himself" (or should we say when his ego catches his acting out?) participating in such a primitive atmosphere, he invariably produces memory associations concerning hostile and tabooed libidinal experiences with family members. Here again it appears to this observer that orientation to the past serves the function of ego restoration following a group-stimulated primitivation or retrogression of the ego. This process of (1) primitivation of atmosphere in response to directiveness, (2) catharsis of pent-up emotions, and then (3) historical association to trauma-like experiences with original family members very easily renders the impression of "reactivation" in the therapy group of emotions consciously and unconsciously belonging to the family group. Actually, however, it may be more precise to think about adult therapy groups in such atmospheres as peer associations in a state of retrogression, rather than describing the situation in terms of group regression or reincarnation of an older (family) grouping.

However this may be, the important thing for the psychotherapist is the efficacy with which the therapy group affords an opportunity for the expression of primitive and other undeveloped emotional needs. Such expression leads to the recognition of previously unconscious inner needs and conflicts. When the ego is strong enough, the patient can start to find new ways of solving, with less conflict, his newly discovered strivings without first having to regress to a supposedly original cause. But most patients' egos are too weak for this growth process. They find it impossible to carry the recognition of the existence of both the intensity and the quality of some of the discovered inner problems without referring them to an extra-ego, historical cause. Thus, participating in a therapy group stimulates fantasies of distant interpersonal family traumata and triumphs. Again the adult therapy group spontaneously accommodates the patient's need for a historical perspective. As we have already reported, the "working through," or rather the talking and feeling about old family experiences, is one of the most popular themes in the group. The more severely disturbed members, whose weaker egos require historical displacements more than the less severely disturbed patients, always see to it that the past is thoroughly reshaped in the hope of a better future.

From a point of view of efficient therapeutics, the working through of old familiar material, for which the therapy group lends itself beautifully, is only an initial step in the basic group therapeutic process, which consists of the patient's "learning," both through cognitive insight and through now-conscious affect experiences, efficiently to seek life satisfactions and to cope with the contemporary problems of his adult membership in the present day grouping. For this reason, we never reinforce, either by word or label, or by fatherly or parental behavior, the idea, which when taken seriously becomes a psychotic illusion, that the therapy group is, in the opinion of the therapist, a reincarnation of the family. Experience has shown that such an emphasis keeps the patients fixated upon the very problems, their childhood fantasy of being hurt, or unloved, or "mean," from which they must depart in order to achieve optimal adult peer adjustment and mature personal satisfaction.

The therapy group is a family group only in a transference or neurotic sense. Older, improved patients who have gained perspective can differentiate clearly between the reality of the adult patient group of peers and the illusion of the reincarnation of the family. Below is reproduced a protocol from an individual session by a group therapy member, who in our experience was one of the patients who used the therapy group most persistently and regularly as a family reactivation stage. This patient (H-F, from our sample Group I) came from a large family with three sisters and five brothers. As the reader already knows from other protocols, this patient had a very traumatic parent and sibling relationship. Because of this background, we feel that her reaction to the group and the differentiation she makes between her family group and the therapy group is of particular relevance in demonstrating our point that the therapy group is definitely a new experience in group living, not just a reactivation of familial and familiar infantile experiences.

PROTOCOL NO. 17: DIFFERENTIATION OF FAMILY  
AND THERAPY GROUP

H-F: I take a lot out on A-M. I can't help it. He reminds me of my brother. But unlike the way it was in my family, I can tell A-M off and he doesn't mind too much. Speaking of families, E-F reminds me of my mother, always worrying about status, always being a focal point for dispensing news and evaluating my brothers and sisters. At the dinner table there was no discretion, nothing was sacred. Everybody seemed to enjoy hearing the worst about everybody else.

Therapist: With this background I am surprised that you participate so well in the therapy group. Isn't it the same?

H-F: Well, it gets quite "hot and heavy" at times, yes. There is a lot of quibbling . . . even dirty words. That's like home. But there is a big difference. [Pause] You see in our group [the therapy group] I can write it all up to experience. I know that everybody there is neurotic. I can't be insulted. Actually, it doesn't feel anything like my family, because I can say to A-M, "You son of a bitch! I resent your male libertinism," while I could never say that, in fact, I didn't even dare to think that about my brothers, who "catted" around all night, while we girls



were forbidden to date. And the funny thing is that I like to help A-M, and at times I even think he wants to help me. That I never felt at home. Everybody there just had depreciatory remarks to make. In our group I don't feel that is so at all. We blow off a lot of steam, but there is no punishment and no ill feeling. Well, [laughs] at least I get over it fast. . . .

### **Reincarnated Family Group vs. Peer Association as Models for the Therapy Group**

The family is only one of several group models which have been found useful to highlight different aspects of life in the therapy group, for no one model represents a prototype for all possible group relationships which can occur in group psychotherapy. The complexity of the interpersonal and inter-subgroup relationships defies the invention of any one model ingenious enough to highlight all the aspects which, for intelligent therapy group management, must be thoroughly understood. The custom of many group therapists to force their thinking about the group into the model of "the family" requires a careful evaluation of the usefulness as well as the limitations of this model.

**The Reincarnated Family.** From the two facts, (1) that the group is a very suitable place to relive and work through previously experienced interpersonal traumata and that (2) the most significant interpersonal traumata usually were experienced by the patients in their relationships with family members, one can predict that patients often will have experiences in the therapy group similar to those they had in the family group. All experienced group psychotherapy practitioners, but particularly those limiting their thinking to the range of psychoanalytic concepts, have noted that many of the therapy group ongoings can be understood in terms of an expression of "reactivations" of unconscious emotional attitudes that prevailed during the participation of the individual in his first intimate group association, namely, his family. There are at least four conditions within any group therapy regime which facilitate reactivations of erstwhile family-conditioned attitudes and experiences.

1. In the first place, it is very unlikely that anyone in the therapy group, since his membership in the original family group,



has participated in the type of *free emotional expressiveness* that characterizes therapy group communications. There is a distinct response-generalization (Hull, 1943). The stimulus quality, for example, of inter-member quibbling and conflicts, of rivaling for the attention of the therapist, of giving advice, and the like, can be easily enough understood as suitable cues for the reactivation of responses to similar stimulation in the past family life.

2. *Response fixation* is a second factor which makes the family group a popular analogy for the therapy group: many neurotics are still, even as adults, deeply involved in an overdue weaning process from their actual initial family. Many patients, according to Speer (1949), are "nest-fixated." This clinical fact of the adult patient's still active involvement in his relationships to mother, father, sisters, and brothers, even uncles, aunts, grandparents and cousins, must be distinguished from "reactivation" and from "transference." The family theme has a transference and reactivation significance only in less response-fixated patients (in the author's practice they are in the majority) who actually come from less cohesive family structures where a high degree of personal autonomy among family members prevailed. Most of these American-Protestant patients have weaned themselves overtly and have left their original nest rather early, either by revolt or otherwise. These "nest-fleeing" patients also have been studied by Speer (1949), who noted that their prognosis is more favorable than those showing a "nest-addiction."

3. A third factor which tends to stimulate a family-like atmosphere in therapy groups is a direct function of the *degree of regression* to passive helplessness of the patient. In group therapy work with patients with severe limitations in contact capacity (such as hospitalized schizophrenics, particularly catatonics) experience has shown that the clinician's attempts, through the use of a second, opposite-sex therapist, and in other ways, to simulate a family setting, are rewarded by such dependent patients' slow and gradual ability to respond. By deliberately simulating in the group therapy atmosphere a naïve family quality, the extreme limitations of psychotic patients with respect to maintaining contact in the more complicated social reality of peer groupings are not put to the test. Even with mild neurotic

patients, the therapy group atmosphere is, to start with, an authority-follower division. The neurotic patient only slowly learns how to manage and maintain membership in a group- or peer-centered order.

Psychotic patients are characterized by their inability to obtain and maintain reciprocal peer contact relationships on an adult maturity level. But they may be able to participate in a dependent type of progressive contact characteristic of the relationship between a helpless child and a strong parent. Group therapists and other therapeutic workers with psychotic patients must for a time cater to this dependent state of affairs by behaving like benevolent parents or big brothers or big sister surrogates. In this way they seize the only chance there seems to be for a psychotherapeutic anchoring point in psychologically regressed patients. For the neurotic whose ego defenses are in fairer shape, the deliberate simulation of a regressive family atmosphere is contraindicated. Surrogate parent roles, which a psychotic handicap forces upon therapists, are not ipso facto the *modus operandi* of group therapy work with disturbed patients.

4. A fourth factor that facilitates the reactivation of familial experiences is the *triggering of delayed reaction tendencies toward parental-like authority*. The refusal on the part of the professional therapist to act in the same authoritatively dominating, possessive, sentimentally "guiding" ways in which the parents once acted does not stop the patients from responding to the therapist in ways which the patients, as children, had suppressed. Now in the therapy group, for the first time, there is a chance to let these delayed reactions come out. This may explain the very ambivalent attitudes, continuing strong hostilities, that patients have toward those other patients who tend to act predominantly in a "parental," advice-giving manner.

**The Therapy Group Usually Not a Family Group.** Concerning the simple analogy: "therapy group equals family group," Foulkes (1951a) from the London Institute of Psychoanalysis sounds this warning:

. . . it is all too easy to interpret his (the therapist's) position really as that of a father or mother and see the group as representing a family. This is *not* my impression. Whereas certain transference reactions be-

tween the members of the group and the leader can *occasionally* be seen, the configuration as a whole does not, by any means, necessarily shape according to the family pattern. It is true that the family is a group but not that the group is a family. I have always maintained that group psychology must develop its own concepts in its own rights and not borrow them from individual psychology. . . . [Italics mine.]<sup>1</sup>

Going along with Foulkes, one can point to many factors in the group therapy situation that are completely unlike the family model, even when a psychoanalytic group therapist tries to simulate it. In the first place, even in the case where there is a male and a female therapist, the two usually are much less intimate than the presumed models. The members of a therapy group of six to nine adults, furthermore, differ radically in their activity, organization (siblings), age range, communication skill, and other factors, from the small family in our culture. Homans (1950) has shown that these factors, rather than a status need to re-experience the familial life, determine group cultures. In the therapy group, the emphasis on group-centeredness is in stark contrast to the father, authority-centered culture of the Freudian, Viennese family model. An unlimited number of items could be added to demonstrate the limitations of the family model analogy for the adult psychotherapy group. The observations of the English psychoanalyst, Bion (1949*a*, pp. 18-19), are relevant:

. . . When the group has come together . . . it has become something as real and as much a part of human life *as a family, but it is in no way the same thing as a family. The leader of such a group is far removed from being the father of a family.* In certain special emotional states, the leader approximates a father, but in this kind of group any member of the group who displays parental qualities soon finds that he has none of the status, obligations or privileges usually associated with a father or mother. Indeed insofar as I, as psychiatrist, am expected to display parental qualities, my own position in the group at this point becomes anomalous, and the expectation operates as an additional reason for my exclusion from the group. . . . [Italics mine.]<sup>2</sup>

A further reminder of the limitations of the family model comes from the sociologists, who point out that there is no such

<sup>1</sup> Quoted from *Int. J. group Psychother.*, 1, p. 319, by permission of the publisher.

<sup>2</sup> Quoted from *Hum. Relat.*, 2, by permission of the publisher.



thing as *the* family. Sociological studies of the social structure of the family reveal that in the United States alone there are some eight types of families which can be structurally grouped into five categories, each with a different kinship structure. In upper-class families, for example, there is some resemblance to a patrilineal system with a tendency toward primogeniture. In lower-class situations, as in parts of India, there is a strong tendency to an instability of father role and to a matriarchal, mother-centered type of family structure. The very nature of this setting greatly influences patterns of emotional response in children, with the mother becoming the identification object as well as the disciplinary agent. *Which* family models the therapy group?

**The Peer Association: Another Analogy Model for the Therapy Group.** We have already mentioned, in connection with group formation in Chapter 4, the resistive "play tendencies" of new group members when they discover that the doctor-authority fails to teach, fails to be punitive and directive. The method by which the therapist keeps the attention of the group continuously focused on itself eventually exposes the neurotic attempts on the part of new patients to set the therapist up as an authority and judge of misdeeds, and then "play hooky" from the set-up authority. There are times during which even older therapy groups will behave in a way best described by analogy to the intensively cohesive juvenile peer gangs of high school adolescents who meet under bridges and behind barns and in car pools, to smoke cigarettes or to do more "libertinistic," anti-authority things. The members of a peer gang are united by their common rebellion against the authority figures. Such a gang formation is often realistically motivated by a need to get away from the power, privilege, and age hierarchy of the family group.

The family group is, by virtue of having members with different biological, cultural maturity, and skill levels, inherently hierarchically structured. It controls its members in terms of relatively rigidly defined roles and privileges. The peer gang, friendship or play group, on the other hand, is not necessarily as hierarchical or as rigidly structured with respect to role. Because of greater similarity in maturity, strength, and skill among its members, it has the possibilities of a democratic mode of life.



## The Significance of Adult Peer Associations

Associative groupings of peers have many advantages for personality development. They are primarily based on relatively more voluntary membership than the biologically determined, involuntarily dependent membership in family groupings. Healthy "human nature" is not only capable of developing outside family group structures, but it definitely needs to expand the medium of interpersonal relationships beyond the family. It is quite possible that any culture that overemphasizes the family as a major source of emotional gratification for its members puts upon the institution of the family a psychological burden which it is incapable of carrying without the price of increased psychopathology among its members.

The capacity of group therapy members, who are initially strangers, to develop as strong an emotional interdependence as they do, definitely indicates that the associative peer type of group organization with its relatively fluid boundary may serve certain emotional needs of the individual that are fully as psychologically significant as the emotional needs served by the family. Associative peer grouping provides a greater number of choices for reciprocal satisfactions than does the hierarchical family group.

Many religious and sociological thinkers have thought the reason for the increased psychopathology in our culture lies in the disintegration of the cohesive, clannish family structure. A new view inspired by creative, modern living in a, materially, fairly secure society sees the family as a limited, rather rigid sphere of contact operations. The popularity of associative groups is seen in the tremendous rise in fraternal orders, the social functions of churches and clubs, the rise of group therapy, and the like. But the "breakdown" of the family need not alarm the guardians of mental health, since the family cannot possibly fulfill all the self-expressive needs of modern man. When parents, especially mothers, have nowhere else to release their emotional energies, all satisfactions must be derived from contact with family members, especially from "guiding" the supposedly helpless and dependent child. One major source of psychiatric disorder in children is maternal overprotection (Levy, 1939).

As a symptom of cultural, social, economic, and biochemical growth, the family will play an increasingly less important role in favor of associative groupings. These latter permit the making of intimate, interpersonal contact on a less automatic, more discriminating choice basis. In associative grouping there is a higher degree of freedom of choice and discrimination. Free choice of association is impossible by definition in the family structure into which the person is born. As modern man recognizes the limitations of the family as a provider of many new interpersonal and creative satisfactions, which his relative material security has made it possible for him to seek, he naturally feels no longer bounded by that which originally was kept together for extra-psychological, namely, economic, physiological, physical, and political protection motives.

The associative peer group is differentiated from the family group by its lesser concern with dependency problems and by its strong concern with the creativity and productivity of mature organisms. Recognition of group needs and putting into effect the skills of *all* available members, in other words, a participative, peer group atmosphere not heavily oppressed by adult authority is more typical of life in an advanced therapy group than any other model.

### Other Group Models and Analogies

In addition to the family and the peer association, many other concepts of group life have been suggested, especially by sociologists and social psychologists. Since these various ideas may aid the group therapist in focusing attention on various aspects of group life, a summary and brief commentary is given.

**The Group as a Sociometric Choice Pattern.** Moreno and Jennings (1934) have, for some time, thought of group structures as the result of selection and choice processes. These workers have been especially conscious of the social interdependence of the human being, which expresses itself not only in responsiveness to social stimuli, but also in an active social expansiveness shown in individuals' attempts to build up a group, or what Moreno calls a "social atom," around him. Moreno has given

the term *tele* to the factor operating to produce group organization through interdependent contact operations. According to Jennings (1950),

. . . The tele process is the operation of the double foci in a relationship between two persons which makes one inter-personal relation, dependent upon both individuals and not a subjective, independent product of either person. . . . The total tele immediately concentrated upon an individual or expended by the individual towards others makes up an emotionally toned interpersonal structure which is termed the "social atom." It is the smallest total structure or nucleus of relations which can be lifted from the whole psychological organization of the group and still retain every part of the structure which is in contact with the individual or with which the individual is in contact.

The significant fact is that a relationship exists between two individuals such that they are not indifferent to association with each other. In this simple fact is the basis of the intricate larger choice-structure which sociometry has shown to exist and to operate and, indeed, to comprise the skeleton of society itself.<sup>3</sup>

Of importance to group therapy management is the question, "To what degree does a given psychotherapy group represent a psychological choice structure?" which is another way of asking, "To what degree are some people in the therapy group isolates?" Naturally, the principle of minimal cohesiveness requires that every person in the group belongs to the social atom in a positive way with respect to one other member in the group at least. An understanding of the tensions in the therapy group is facilitated when the conductor is aware of tendencies to discard and resolve relationships, for the need to obtain therapy is a force which keeps patients in therapy groups, even when from the standpoint of a sociometric choice the majority of their interpersonal relationships are negatively toned. Such a state of affairs may not become automatically manifest and tension may then be displaced, making a clear understanding of the tension situation in the group difficult. The sociometric-like assessment techniques used in our sample regimes and discussed on pp. 178-189 help to keep abreast with the ever-changing pattern of the tele process in the therapy group.

<sup>3</sup> Quoted from H. Jennings, *Leadership and isolation* (2d ed.) by permission of Longmans, Green & Co., Inc.



We have already noted Jennings' (1950) differentiation between the psychegroup as against the sociogroup. Jennings stated that the sociogroup is modeled by the hypothetical situation in which an individual will put aside much of the expression of his private personal needs in order to maintain a role in a common group enterprise which satisfies largely impersonal values, especially in terms of material survival. According to Jennings (p. 278) :

*Sociogroups* are groups characterized by a sociometric structure which is based on a criterion which is *collective* in nature; such a socio-criterion is working in a *common work unit* (as a shop or office); the tele between the persons *in respect to collaborating with one another* in such sociogroups may be called *sociotele*, since it is founded upon response towards remaining with or wishing to depart from such association in the specific common situation. Sociotele has, in this sense, a *largely impersonalized* base. . . .<sup>4</sup>

A person's sociogroup participation, characterized by shared, formalized experiences common to several members is contrasted to a person's more individualistic, noninstitutionalized personal relationships, which have a more intensive quality of mutuality. This is the structure of interpersonal relations in the psychegroup (Jennings, 1950, pp. 278-79) :

*Psychegroups* are groups characterized by a sociometric structure which is based on a *private* criterion which is totally *personal* in nature; such a *psyche-criterion* is *associating in the time the individual has at his voluntary disposal* (as in leisure-time); the tele between the persons *in respect to associating with one another of their own accord* in such psychegroups may be called *psychetele*, since it is founded upon response towards associating or not associating with others as a purely personal matter. Psychetele has, in this sense, a *largely personalized* base. . . . [Italics mine.]<sup>4</sup>

Using Jennings' model structures, one might say that the psychotherapy group starts as a sociogroup in the sense that it is a common group project with at least one person, the therapist, playing a technically and culturally defined role. Also at first patients react to each other in terms of being "co-patients." New

<sup>4</sup> Quoted from *ibid.*, pp. 278, 278-79, by permission of Longmans, Green & Co., Inc.



patients and new groups make frequent reference to "the reasons I am here," emphasizing the communality aspect. As the therapy group grows, the quality of the group changes from socio- to psychegroup. With experience and security in the group, members react to each other individualistically, not as patient to patient, but as person to person. The emphasis on freedom of expression fosters the communication of very personal feelings about each other. In a sense it can be said that the goal of the therapy group management is effectively to change the structure of the group from a sociogroup into a psychegroup.

While the psychegroup process is the most frequent focus of attention of therapy groups (Coffey, 1952), therapy groups are actually in a peculiar category, which may involve the suggestion of a third type of grouping which falls in between the sociogroup and the psychegroup, insofar as a certain amount of productivity, problem solving, and work anxiety are involved in therapy groups, which, as all participants know, is not all in the nature of having a good time. Similar to the sociogroup is the fact that, as in society, therapy groups lay down limits with respect to roles and norms, which must be conformed with, whereas in the case of psychegroups, what individuals will do with each other is relatively more free, with the relationship devoted to interpersonal tension release without any of the limits inherent in the kind of self-evaluating processes occurring in therapy groups.

**The Group as a Role Structure.** Closely related to Moreno's and Jennings' suggestions with respect to sociometric group structures is the idea that many social psychologists have advanced to represent groups in terms of their role structure. By describing the various roles in which members function, one can compare different groups and the same group at different phases. Both the variety and quality of emotional intensity of roles can be observed to change in the course of group psychotherapy, as research by Coffey, Freedman, Leary, and Ossorio (1950), and by Freedman, Leary, *et al.* (1951) has made clear. It is helpful for a group therapist to know what the actual and the potential role repertoire is in any given group.

Often difficulties in group management are overcome when, through the group's self-awareness of its own group dynamic

situation, it detects the need for someone to fill a certain group-needed role. A very simple example of a group-needed role would be the timekeeper. A more complicated example would be the guardian of "democracy," who effectively restricts narcissistic misuses of the group by dominating members. In this connection it is helpful to think of the role model as independent of individuals. Leadership functions can be thought of in terms of leader roles which are filled by several members of the group. This also applies to other roles. For example, the group role of providing humorous tension releases, always needed in any face-to-face group setting, can be and is filled by a variety of persons, although it is true that some members more characteristically participate in fulfilling this particular or any particular role than do others.

**The Group as a Communication Exchange.** Clinicians often look upon the group as analogous to a communication exchange center, where members put in and receive communications. A group life emerges from the simultaneous use of this communication exchange by a number of people, each trying to reach the appropriate co-communicator. Another way of describing this type of model is in terms of the group as a market place for exchanging tension-reducing opportunities. This involves a give and take process, which, in order to avoid chaos, requires some sort of regulation of interpersonal traffic. This need for regulation of interpersonal communication creates value systems, group rituals and roles. This model draws our attention to factors that tend to "jam" or to keep open communication channels. When applying this particular model, sociopathology can be seen to be related to the clogging of the communication process by which the human being tries to obtain better opportunities for expressing his interdependence with other human beings (cf. Ruesch & Bateson, 1951).

The suggestions of models for life in the therapy group could be expanded and elaborated, but such a discussion would go beyond the purposes of this volume. Research undoubtedly will provide more incisive models of group life.

## Group Observational Dimensions

Methods of studying group life are rapidly developing as more systematic attention is paid to the scientific investigations of human relationships. The conceptualization of basic dimensions of group life has been the traditional concern of sociologists and social psychologists, whose contributions are summarized in textbooks. Of particular interest to the group therapist are studies and theories of small cohesive human groups. The recent book, *The Human Group*, by the sociologist Homans (1950), is of interest. Homans postulated certain group dimensions including "activity," "sentiment," "interaction," and "norms," and analyzed in great detail their mutual dependence. Homans stresses, for example, that norms or value systems are not isolated "cultural forces" but that they "emerge from ongoing activity." Various other schemes and classifications of so-called dimensions of group life are now available, enabling the systematic observer to make more specific quantifiable comparisons between various groups (cf. Jahoda, Deutsch, & Cook, 1951).

Schemes of dimensional analyses may eventually lead to the recognition of sociopathological patterns in groups. When well-functioning and ill-functioning groups can be systematically compared, the factors that make for social pathology can be isolated. As work along this line is progressing, the group therapist will eventually profit from it, in the sense that he may be able to apply instruments of sociopathological diagnosis to his own groups and thus become more keenly aware of possibilities for improving the effectiveness of his groups.

## Beyond Freud's Group Psychology

In a vivid description, that left no doubt as to what he thought of groups, Freud's brilliant pen elaborated on LeBon's and McDougal's classic observations of man's emotionality when "under the influence of a crowd and its leader." The following is a quotation, selected by Thomas Gordon (1951a), from Freud's *Group Psychology and the Analysis of the Ego*:



A group is extraordinarily credulous and open to influence, it has no critical faculty, and the improbable does not exist for it. . . . Inclined as it itself is to all extremes, a group can only be excited by an excessive stimulus. Anyone who wishes to produce an effect upon it needs no logical adjustment to his arguments; he must paint in the most forcible colors, he must exaggerate, and he must repeat the same thing again and again. . . . It respects force and can only be slightly influenced by kindness, which it regards merely as a form of weakness. . . . It wants to be ruled and oppressed, and to fear its masters. . . . And, finally, groups have never thirsted after truth. They demand illusions, and cannot do without them. They constantly give what is unreal precedence over what is real; they are almost as strongly influenced by what is untrue as by what is true. They have an evident tendency not to distinguish between the two. . . . A group is an obedient herd, which could never live without a master. It has such a thirst for obedience that it submits instinctively to anyone who appoints himself as its master.<sup>5</sup>

It is easy to see why the above quotation may not appeal to Anglo-American psychotherapists, reared in the democratic tradition which cautions group and therapist *not* to use force. Today accepting attitudes are not felt to be "weakness," and reinforcing illusions is against the principle of reality. How could one work as a group therapy practitioner if one believed the group's nature to be that expounded by Freud? Understandably, a very different view of the psychological nature of the human group must provide the basis for group psychotherapy.

S. M. Wesley,<sup>6</sup> a careful student of psychoanalysis, has suggested a reason for the fact that Freud's *Group Psychology* cannot possibly serve as a theoretical basis for group psychotherapy practice. Wesley suggested that Freud in his *Group Psychology* was not thinking of small, stable, intimate, face-to-face groups with high levels of member-member or peer interdependence (such as therapy groups), but that his remarks, as quoted above, referred to large mobs or crowds. The mob or "crowd," Wesley points out, is distinguished from the "group" by various parameters, such as unilaterality, reduction of communication and a

<sup>5</sup> From: *Group psychology and the analysis of the ego*, pp. 15-21, by Sigmund Freud. Liveright Publishing Corporation, New York. Hogarth Press, London, England.

<sup>6</sup> Personal communication (1952).



low order of abstraction. The large size of the crowd, the irregular and fleeting contact, low cohesiveness and weak interpersonal responsibility, all instigate, according to Wesley, id forces which weaken the ego function. In such mobs and crowds emotions are more primitive, child-like, more in the nature of pure transference of dependency, than are the emotions prevailing in the more intimate and stable human peer groups, which actually help the ego to grow and strengthen it. Thus, while Freud's description of the loosely connected large crowd may have much validity, his mob model fails to elucidate the ego-strengthening forces present in the therapy group.

Today many psychoanalysts who are interested in group psychotherapy are fully aware of the specific and limited value of Freud's group psychology. For example, in Rickman's view (1950), Freud's concepts are limited to Oedipal dynamics based on observations "of single persons who failed to master the complexity of the three-body [Oedipal situation] and who, therefore, transfer into *any* situation those as yet unresolved three-body problems." Many colleagues have gone along with Rickman and have recognized the rigidity and the constriction inherent in the theory that the human group is simply an avenue into which the individual transfers his unresolved Oedipus complex by becoming an obedient and faithful follower.

When the neurotic patient steps from the neurotically stimulated and reactivated parent-child relationship of individual analysis into the public-social interactions of a group of six to ten patients, there is a great deal of evidence that he is capable of mature behavior. Powdermaker and Frank (1948), for example, noted that the intersupportive, authority-defiant tendencies can sometimes be more characteristic of therapy groups than the dependent follower attachment postulated by Freud. Freud's exclusive emphasis on the submissiveness of members to leaders and to authority has had a limiting effect on the understanding of the group therapy process. One can expect only disappointments from studies limited to a "leader principle" frame of reference, because such studies invariably overemphasize one part-process in the total social field: the role of the central figure. One need not deny the fact that individuals gather in groups

under certain circumstances to express submissive-dependent, inspiration-seeking moods, and that there are always individual "leaders" ready to nurture such a mood. This is obvious in the behavior of "successful" business and political leaders, and popular entertainers. Even in the practice of group psychotherapy, a novice may be unable to resist the temptation to behave so that the group will "love him" for fulfilling its need for the illusion of the greatness of its leader, or the power of the "doctor."

Freud's belief in man's uncriticalness in groups was quite in line with one of his main professional interests: the proof that man's actions are largely determined by unconscious strivings and that the unconscious strivings are ipso facto primitive and narcissistic. Freud was interested in a group, as he was in a dream: both were occasions when Freud could demonstrate the animalistic, emotional irrationality of man's unconscious rather clearly. It is this property of the group effectively to instigate the unconscious that makes the group such a suitable medium for deep psychotherapy. Group participation encourages the expression of "deep" needs. But such expressions are not restricted to infantile dependency, rivalry, and other negative emotions; they also include such positive emotions as affection, constructive mutual aid, and peer love.

Freud overstressed the leader-dependent, the authority aspects of group life; he overemphasized regression and primitivity. His whole theory that unconscious strivings are "bad" and that special control, or "sublimation" of primitive instincts is a necessary condition for mature socializing makes the practice of group therapy theoretically paradoxical, for the group is very effective in awakening all unconscious urges. If they all were "bad," group therapy participation would lead to trauma and psychosis when, in fact, it is an ego-strengthening process. Freud's concepts of the nature of the unconscious must, therefore, be expanded to include all the unconscious processes observable in the participants of intensive group therapy.

Even before Freud first published his *Group Psychology*, social psychologists like Vierkandt and L. von Wiese concerned themselves with methods and concepts for the investigation of

the relationships between persons. As a result of Wiese's "Beziehungslehre" certain dimensions, such as closeness, distance, and the need value of one person for another, were developed and applied in field studies of actual groups long before psychoanalytic concepts of group life came into vogue.

About the same time as Freud wrote his *Group Psychology* several psychologists working with Kurt Lewin at the University of Berlin had brought interpersonal and group processes under experimental scrutiny in psychological laboratories. Tamara Dembo (1931), for example, studied the social power relations between experimenter and subject, and Wiehe (1934) studied the psychological effects of strangers on groups.

### The New Group Dynamic Orientation

Further progress in the scientific study of group life was halted by the decline of democratic thought and the renaissance of primitive leader-dependency in German-Austrian culture and by World War II. Only a few German writers, such as Speer (1949, 1951), were able to continue their interest in interpersonal processes. It took some time before these pioneer studies could be continued in American psychology research and therapy centers. Today in research centers of group dynamics at the University of Michigan, at the University of Minnesota, and other places, "group-dynamic" research on cohesiveness, contagion, dynamics of power, group panic, style of leadership, on communication patterns, and on group frustration are in progress. They have already increased our knowledge concerning the psychology of groups.

The psychological discipline of "group-dynamics" brought to life by Kurt Lewin promises to provide a sound theoretical basis for group therapy practice, and considers it fruitless just to list certain isolated items characteristic of small aspects of group life. In the new dynamic view one considers leadership as a "role," a group life function, that can be fulfilled by all members, rather than by one "leader-personality." In contrast to the old interest in finding identities (such as a common love or fear of the leader) among individuals as a basis for understanding



their willingness to live together in groups, the dynamic approach would specify the nature of the total field that would be necessary for commonness of experiences either to increase or decrease the cohesiveness and interdependence of individuals in a group.

Under certain social field conditions, heterogeneity and individualistic *uncommonness* between members may increase rather than decrease cohesiveness. Isolated single factors, such as fear or love of leader, or several common, "basic" emotions, are in the field of theoretical thought and language pattern specific phenotypic aspects of a multidimensional process which one seeks to relate to a genotype. Psychological phenomena are no longer described by phenotypic, Aristotelian concepts based on the classification of similar and dissimilar categories. Contemporary researchers try to recognize the dynamic essence of a given psychological or interpersonal process and define it conceptually by way of models or hypothetical (genotypic) situations. For a clear exposition of this type of thinking about socio-psychological processes the reader is referred to Kurt Lewin (1948, 1951) and his former students: Cartwright (1951), Cartwright and Zander (1953), J. F. Brown (1936), Lippitt (1949), Festinger (1950*a*, 1950*b*), and French (1950).

The change in conceptualizations concerning the group which has emerged from the new group dynamic orientation and which is of concern to the group therapist refers to the functions of group leaders. In a rather peculiar and somewhat unique sense psychotherapists who employ the group medium are "leaders." Therefore, these new concepts of leadership are of particular interest to them.

All contemporary views on leadership emphasize rather than play down the important influences that carriers of leadership roles may have. LeBon's, McDougal's, and Freud's sensitivity to the potential power of a leader to effect group dynamic changes is, as a general proposition, shared by the new orientation. Especially in authoritarian settings with hierarchical power structures common in American industry, "the style of personal leadership of the face-to-face group is probably the most important variable" (French, 1950) in determining the industrial work productivity of groups carefully studied by French.



But the contemporary social scientist is not satisfied with the mere recognition of the importance of the person of the leader. He goes further and attempts to investigate the conditions under which these important leadership functions can best be fulfilled by the group. We have already noted the usefulness of the "sanctioned role" concept of leadership. It is now recognized that only when certain leadership functions are decentralized can the individuals belonging to a group express more than just the most primitive emotions, needs, and moods. This new concept of leadership has been expressed by Thomas Gordon (1951a):

Leadership . . . [is] a set of functions, not vested in a single person, but rather functions which must be carried out by the group. Leadership is, then, not a role to be played by one member of the group, but rather a set of functions to be performed within the group in order that the group may make adjustments, solve problems, and develop its potentials. . . . the adjustive behavior of the group will be most appropriate when each member is free at any time to take on some of the functions of leadership. . . . This state rarely exists in groups. Most organizations operate far from this ideal. It is rarely possible to say of a group that its leadership is distributed or that its members are making maximum contribution.

The very existence of a group leader, either real or perceived, may be a deterrent to the distribution of leadership throughout the group.<sup>7</sup>

The above concept of group leadership rests on the basic hypothesis, first formally advanced by Kurt Lewin (1944), that groups, like the individual, have self-regulating processes designed to maintain the group. On the basis of his group therapy experiences, Hobbs (1951) has rendered the following expression of this basic hypothesis about group life:

. . . the best decisions or the most appropriate actions of a group will be those based upon the maximum amount of data or resources of its members. Thus the most effective group will be the one in which there is participation of all members, each member making his most creative contribution.

. . . A group has within itself the adjustive capacities necessary to acquire a greater degree of internal harmony and productivity and to achieve a more effective adjustment to its environment [boundary].

<sup>7</sup> Quoted from Chap. vii in C. Rogers, *Client-centered therapy*, by permission of Houghton Mifflin Co.

Provided certain conditions are met, the group will move in the direction of greater utilization of these capacities.<sup>8</sup>

The application of these newer concepts of group life to group therapy inevitably leads to the kind of practice described in parts I and II of this book. Being now acquainted with the general new orientation, we shall turn our attention to specific group concepts and models.

### The Meaning of "Group Dynamics" and "Social Field"

Kurt Lewin's (1951) theoretical field approach to the study of group life has indirectly yielded many new experimental results with important implications to group psychotherapy practice. The practical importance of field theoretical research to the group therapist is obvious when one considers that many of the studies of group dynamics are concerned with changing some behavior pattern within the individual, such as his productivity (Lewin, 1947), by changing the nature of his social field. This is no different from the use of the social field of the therapy group to change a neurotic patient's way of life.

The field model symbolically represents the empirical fact of multidimensional determination of behavior. It thus keeps the observer's eyes open to various aspects of interdependency which other concepts simply have no way of expressing. To avoid the misinterpretations that the labels "field" and "dynamics" frequently receive, the following clarification is suggested: *group dynamics* refers to the phenomenon of interdependence of interacting members. By the "field" concept one means nothing more than the fact that a *part* process (such as a therapeutic experience by *one* member of the group) affects other part processes (other members' therapeutic experiences), as well as affecting the total medium (for example, the subgroup structure of the therapy group).

Krech and Crutchfield clarify these concepts as follows:

... The criterion that can be applied for recognizing a group, simply stated, is whether or not the behavior of other members of the supposed

<sup>8</sup> Quoted from C. Rogers, *Client-centered therapy*, by permission of Houghton Mifflin Co.

group seems to have any direct influence on the behavior of the given individual and whether or not *his* behavior, in turn, has direct effect on the other members. This statement of interaction suggests the definition of . . . *dynamics*. Nothing more esoteric is meant by the word dynamics than the connotation of *adjustive changes occurring in the group structure as a whole, as produced by changes in any part of the group*. . . .

. . . Field phenomena, as found in physics, depend upon the fact that the processes occurring at one point have effects throughout the field because the medium in which events occur is itself affected. This is true of "psychological fields" and of "social fields." . . .<sup>9</sup>

Krech and Crutchfield do not fully clarify the fact that the social field or the group is a medium which has characteristics that can be—and sometimes this is the only way possible—described without reference to properties specifiable within any given individual group member. On this point the following discussion by Kurt Lewin may be quoted:

There is no more magic behind the fact that groups have properties of their own, which are different from the properties of their subgroups or their individual members, than behind the fact that molecules have properties, which are different from the properties of the atoms or ions of which they are composed. In the social as in the physical field the structural properties of a dynamic whole are different from the structural properties of subparts. Both sets of properties have to be investigated. When one, and when the other, is important, depends upon the question to be answered. But there is no difference of reality between them. If this basic statement is accepted, the problem of existence of a group loses its metaphysical flavor. Instead we face a series of empirical problems.<sup>10</sup>

The concept of group dynamic processes is a tool to the understanding of interpersonal happenings in therapy groups. Group dynamic concepts enable us to extend our language to describe processes which are largely unobservable in any one member and which need for their demonstration two or more people interacting with each other. Therefore, the phenomenological

<sup>9</sup> By permission, from *Theory and problems of social psychology*, by D. Krech and R. Crutchfield. Copyright, 1948. McGraw-Hill Book Company, Inc., New York. P. 19.

<sup>10</sup> By permission from *Field Theory in Social Science*, by Kurt Lewin. Ed. by D. Cartwright. Copyright, 1951. New York: Harper & Bros.



definitions of individually oriented psychology cannot be useful for this purpose. In other words, the group has demonstrable effects on the individuals without our being able to specify the cause of this effect as "residing" in any *one* independent member of the group. That is, dynamic group psychology concepts describe characteristics of a hypothetical state called "the group," such as its structure and cohesiveness, and these may not refer to any specifically observable characteristic in an individual or the simple sum of a number of individuals.

This is by no means metaphysical and has, in fact, close analogy in modern physical theory. The author refers to the theory of particles. According to modern physical theories, particles may exist in "virtual" states in which they may have observable effects although they do not actually exist as independent observable particles.

In an analogous sense, eight human beings together may form a virtual state, a social field, in which it (the social field) may have observable effects on each member, although the state, or social field, or "group" is not actually existent as observable, independent of each member. In admitting "social field" and "group" as useful concepts, one does not fall into the metaphysical pseudo controversy of whether a group or social field exists or not. One simply "posits" that it exists (Reichenbach, 1951).

Traditionally oriented psychotherapists often dispose of the factors of group dynamics as of secondary import, or even as irrelevant, relative to individual motivational factors inside the patient which the patient brings to and injects into the group. Our own position takes full account of the fact that the neurotic and psychotic patient helps to create group tensions in pathologically tense fields as a result of his intradermal conflicts. But this "intradermal position" does not discount the very real reciprocity and interdependence of person and social field.

The contemporary position can be expressed in the following specific definition of a person's social field: the range of possible interpersonal contact operations is not alone determined by intradermal personality dynamics (need-tension, perceptual organization, acting out patterns, etc.) but is also determined by the dynamic characteristics of the social field. For any given in-



dividual (P), the social field (SF) at a particular time situation (TS) is defined as the constellation of interaction opportunities or contacts (C) with other persons available to P *as perceived by P*.

## Chapter 19

### APPLICATION OF GROUP DYNAMIC PRINCIPLES IN THE CLINICAL MANAGEMENT OF THERAPY GROUPS

---

#### Interpreting Covert Group Dynamics

Researchers in group dynamics have recognized that every human group meeting has in addition to the official and overt order of business a "hidden agenda." The hidden agenda consists of vaguely recognized, suppressed or deeply unconscious needs and interests of one or more members which they "wish" to express or are, in fact, behaviorally expressing in the group. For the practice of group psychotherapy one needs to know something about unconscious forces of group dynamics. To carry out the therapeutic technique of interpretation of a patient's personal, idiosyncratic participation, one must know, according to Bion (1948-51), to what extent the individual simply gives expression to the "hidden" attitudes and interests of the majority of the group.

It is necessary, therefore, to differentiate the explicitly stated, manifest group goals from the underlying operative group goals, and from the personal goals of each member. The practitioner may wish to think of the therapy group as a work group consciously and logically proceeding to facilitate self-corrective and growth processes. This is the clinician's work goal for the group, and he is interested mainly in "techniques" that will help him to achieve this explicit work goal. But this goal may or may not be his own unconscious goal and the goal structure of the participant patients is, to be sure, far more complex than this. Many responses of the individual in a group are influenced to a consider-

able degree by instigating forces arising from the dynamic forces of the group.

There is, not only for the therapist but also for the patient, a direct and immediate advantage to becoming aware of these dynamic factors during group therapy work. When the therapist, or any other alert observer, can on occasion communicate to the group his understanding of the here-and-now manifestations of some covert factor of group dynamics, most patients seem to obtain some relief from such insight into these group processes, as if the solution to an unstructured puzzle is sensed. The lasting effects of the patients' themselves becoming aware of the processes of group dynamics has already been mentioned.

### **The Selection of Clinically Relevant Group Dynamics**

Naturally, psychotherapists are not interested in all studies of group dynamics. As a matter of fact, a large proportion of these studies in no way clarify the processes most relevant to group therapy. These are studies of the group processes on the level of, say, intergroup relations, where the movement of the group relative to another group is the focus of interest. It is generally true that wherever the group as a whole is treated as the unit of analysis, as in many of the studies by social psychologists, they are of less value to the clinician than when the research includes the level of individual interaction. However, some valuable clues may even then be obtained. A study of intergroup relations may yield some valuable insight applicable to the interrelations of the subgroups and "cliques" within a therapy group, to which our attention will turn in a later chapter.

The selection of those aspects of group dynamics that are most relevant to psychotherapy is at present very difficult for want of adequate criteria. Such selection should obviously depend upon an understanding of the relationship between the therapeutic or self-correction process occurring in each individual patient-member and one or more dynamic processes occurring in the group life. Our present state of knowledge does not cover in any way these relationships between individual social learning phenomena and group life characteristics. In the absence

of precise statements of the nature of the interdependence of individual and group dynamics, one can proceed only with the listing of various tentative suggestions found useful as orientation points for practice.

The author's own interest has been particularly drawn to the following three aspects of the dynamics of group life:

1. Kurt Lewin's genotypic concepts and models mediate a deeper understanding of the phenotypic ongoings in which group practice involves the therapist. In this chapter a brief summary and evaluation of several of the contributions made by theoretically field-oriented researchers will be given.

2. Practice, teaching, and research in psychodynamics and psychotherapy naturally lead to a more direct and specific study of group therapy dynamics than are attempted by the systematic researchers in group dynamics. The author's interest centers on the dynamics of group tension in relation to therapeutic process, leadership, "resistance," neurotic transference (set-up operations), isolation fears, group boundary anxiety, and the like. The dynamics of social, therapeutic, and neurotic subgroup coalitions have also attracted our attention for several years.

3. Repeated observations of the effectiveness of patients' therapeutic services to each other has led to a re-evaluation of the nature of the group and the place of leadership and authority in a group. The author has found it particularly helpful to take a "group-centered" or "peer-attitude" toward therapy groups. As a consequence, overevaluation of the professional therapist-leader influences is avoided. Instead, a positive search for an adequate estimation and evaluation of patient-patient, co-therapeutic potentialities has been undertaken.

Below a brief selection from the rich harvest of new knowledge of psychological forces that affect group and individual behavior, which studies of group dynamics have yielded, will be discussed with reference to group therapy practice. This knowledge, most readers will be aware, was obtained outside the clinical setting of group psychotherapy practice. These workers were interested in finding systematic laws of social psychology, and they did not relate their findings to the practice of group therapy; to do so is our present objective.



The ambitious attempt of Kurt Lewin (1951) to represent leader-follower, in-group out-group relationships, and other observable group proceedings by imaginary field forces and with quasi-mathematical, topological concepts has been extremely productive of new research approaches to the field of group dynamics. Communication blocks between systematic researchers and clinician-technologists usually prevent one from profiting by the other. The systematic researcher looks for field and laboratory conditions in which he can manipulate some variables and obtain relevant measurements of the forces operating in groups. The clinician-practitioner, being charged with the welfare of individual patients is, as a rule, interested only in practical "techniques" which may enhance therapeutics. Responsible clinical preoccupation with the welfare of individuals does not necessarily exclude, however, the recognition of the close interdependence of "personalistic" behavior and dynamic forces in the group. We have already discussed the studies which have illuminated this interdependence. As research in group dynamics proceeds, it is becoming more and more evident that more effective methods for changing individual behavior, the very thing that the psychotherapeutic clinician is vitally interested in, can be obtained through a better understanding of the group's influence on behavior changes in its members.

Cartwright (1951) rendered an invaluable service to the practitioner by summarizing in eight principles some basic implications of group dynamic research findings to the practice of changing individual behavior. In the discussion below we shall restate or paraphrase Cartwright's principles. Since Cartwright does not specifically relate his principles to group therapy management problems, the writer will attempt to indicate how these principles of group dynamics can be utilized in group therapy practice.

### **The Group as a Medium of Change: Eight Factors of Group Dynamics**

**Principle No. 1.** If the group is to be used effectively as a medium of change, those people who are to be changed and those

who are to exert influence for change must have a strong sense of belonging to the same group (Cartwright, 1951).

This principle of cohesiveness is most relevant to the therapy group, for much of the therapeutic process is mediated by all members. The most unique feature of group therapy is the co-therapeutic influence of peers, not of the doctor alone. Traditionally, the doctor (therapist) is thought of as having the most influence, but in group therapy this is actually not necessarily so, because the relatively low degree of cohesiveness between doctor and patient as compared with the often very deeply involved peer relationships between the patients gives the co-patient a greater power of effective influence. The lack of cohesiveness, the social role gap, between doctor and patients may block the effectiveness of his influence on the behavior of his patients. This is an instance of the condition of low "we-feeling" between doctor and patient. Kurt Lewin (as quoted by Cartwright, 1951) observed:

. . . The normal gap between teacher and student, doctor and patient, . . . can . . . be a real obstacle to acceptance of the advocated conduct. In other words, in spite of whatever status differences there might be between them, the teacher and student have to feel as members of *one* group in matters involving their sense of values. *The chances for re-education seem to be increased whenever a strong we-feeling is created.* [Italics mine.]<sup>1</sup>

Cartwright also makes reference to various experiments which have demonstrated greater changes of opinions among members of discussion groups operating with *participatory leadership* than among those with supervisory leadership (cf. Gibb *et al.*, 1951).

What does the principle of cohesiveness or "we-feeling" mean to group therapy practitioners? How can the therapist, for example, bridge the natural leader-follower gap? Each therapist will use his own personal approach gradually to develop and increase a we-feeling between the patient and himself. However, it would be clinically naïve to assume that the attempt to make disturbed individuals (who have strong unconscious fears of the authority of the doctor) have a "we-feeling" with the doctor they fear (that is, feel accepted by him and on a par with

<sup>1</sup> Quoted from *Hum. Relat.*, 4, by permission of the publisher.

him) depends on the right technique. Experience has shown that closeness to patients in the form of countertransference acceptance would only intensify resistance. Practice has taught us to play a reserved role of respectful acceptance—not too intimate, yet not too distant or clinically aloof. Practice teaches us to “let the patient lead and cue” the therapist for his inner readiness to overcome the doctor-patient distance and to develop an optimal level of cohesiveness in this relationship. In fact, overcoming the unconscious fear of the doctor-authority is a central part of the therapeutic process.

In exclusively individual psychotherapy practice many of the premature terminations and unsuccessful treatment cases result from a failure of the doctor-patient pair to make progress toward the difficult goal of achieving an optimal level of cohesiveness between the two. In the larger therapy group, several conditions favor the quicker development of a strong sense of belonging on the part of an individual patient. One of these conditions is that the experienced power or status gap (real or imagined) between any one patient and another is never as great as that between any one patient and the doctor. We can now derive a corollary statement to the effect that, at least in the first half of the therapeutic course, patient or peer influence for change is more effective than the therapist's influence.

These theoretical considerations form the basis for three practical techniques: (1) facilitating, in the ways already discussed in various chapters, direct patient-patient contact and influence; (2) keeping the direct therapist-individual patient influence within the channels outlined by the patient himself and by the consensus of his co-therapist peers; and (3) refraining from applying “the weight of authority” (Homans, 1950) in the therapist's personal mode of participation at the group meetings. The patients' experiences with participation in building up a culture in the therapy group are one of the most effective factors in producing optimal degrees of cohesiveness in the group. Foulkes (1946) was the first to suggest the group therapy technique in which the therapist considers it a group job to ease tension and solve other management problems. Explicit participation in the group's self-regulation process reinforces the



we-feeling, as such participation dramatically highlights the actual psychological interdependence of member with member.

**Principle No. 2.** Cartwright's (1951) Principle No. 2 has to do with the quality of emotional satisfactions derived from group participation. Cartwright writes:

*. . . The more attractive the group is to its members the greater is the influence that the group can exert on its members. . . . In more cohesive groups there is a greater readiness of members to attempt to influence others, a greater readiness to be influenced by others . . . Important for the practitioner wanting to make use of this principle is, of course, the question of how to increase the attractiveness of groups. . . . A group is more attractive the more it satisfies the needs of its members. We have been able to demonstrate experimentally an increase in group cohesiveness by increasing the liking of members for each other as persons. [Italics mine.]*<sup>2</sup>

These findings in group dynamics are in line with the group therapy practice by which patients are afforded every opportunity to know each other as social persons, that is, to get to like each other. Also relevant for applying Principle No. 2 to group therapy is the practice of selection of group members in such a way that all *can* eventually like each other. Member-member liking is impeded when, through improper selection, one or more individuals cannot psychologically or sociologically dovetail with a majority of the group. An example would be the placing of a seriously disturbed psychotic patient in a group of mild neurotics. The task of getting to know and to like a severely disturbed person is too difficult and discouraging. This principle emphasizes the need to select mutually fairly congenial people. It puts a limit on indiscriminate heterogeneous selection (cf. Chapter 2).

**Principle No. 3.** In attempts to change attitudes, values, or behavior, the more relevant they are to the basis of attraction to the group, the greater will be the influence that the group can exert upon them (Cartwright, 1951).

The basis of attraction to the therapy group is the improvement of mental health and interpersonal relationships. The group will be most influential on its members in this area. This

<sup>2</sup> Quoted from *ibid.*, by permission of the publisher.



principle may explain why therapy groups, although they are made up of emotionally maladjusted and interpersonally handicapped individuals, as a rule do not reinforce each others' pathologies, and why they are so impressed and interested in any sign of progress on the part of any member in the direction of more effective interpersonal relationships and increased feelings of well-being. The perception of social behavior which has a disjunctive or anxiety-evoking effect in the here-and-now of the life of the therapy group is also a matter of great relevance to therapy group participants. These perceptions set the stage for therapeutic discriminatory learning of people's emotional and interpersonal sensitivities. This principle of group dynamics, by which only values that are relevant to the goal of the therapy group can have a definite effect on the individuals, safeguards group therapy procedures against the dangers of therapeutically irrelevant or even deleterious member-member influences. The soundness of this psychological principle is often demonstrated in the majority's rejection of antitherapeutic tendencies shown by some patients who wish to use the group exclusively as an acting-out stage.

**Principle No. 4.** In Principle No. 4, Cartwright (1951) repeats a well known observation, which has recently been confirmed in a series of studies in children's camp groups by Polansky, Lippitt, and Redl (1950*a*, 1950*b*): the greater the prestige of a group member in the eyes of the other members, the greater the influence he can exert.

Applied to the management of therapy groups, this principle encourages a careful study of the behavior or the roles that give prestige to both therapist and patients in the group. We can distinguish two classes of prestige sources in therapy groups. The first source of prestige has to do with status and achievement in the macrocommunity. It is on the basis of this outside prestige source that the doctor-therapist obtains his initial position. Depending on whether or not the group will continue to give the therapist prestige and standing after knowing him in the repeated and rather intimate participant relationship in intensive therapy groups, he may or may not lose this initially high status. In other words, while the initial prestige and influence potential

is a function of macrocommunity standing, the later and final prestige position depends on the in-group or microcommunity status of the person. The high impressionability of patients in the early phases of group therapy is used by the therapist to influence the patients effectively in developing a peer group-centered, rather than an authority-centered, attitude.

Paradoxically, this rather remarkable switch of attitude from the natural authority expectations of the patients to a participative, co-working role could not be achieved without the initial high status and authority position of the therapist. It is a good thing that the skills involved in being an effective psychotherapist involve a long process of training and study and the accumulation of degrees and other symbols of macrocommunity status. Without the initially powerful influence of the prestige person, the development of group-centeredness would be practically impossible. This can be demonstrated when, owing to mistaken selection, a psychopathic personality with authority-ridden values and antidemocratic attitudes but with high economic and social status in the macrocommunity, finds a place in the group. Experience with such patients, of which we have seen many, shows that they will immediately try to interfere with the development of a group-centered culture, attacking the "defaulting" therapist-leader as "weak" or "incompetent" to lead. Such a psychopaths' group-destructive behavior may be initially very influential and contagious in a young, inexperienced group, because many psychopaths have high economic and business prestige in the macrocommunity.

#### **Sources of Derived and Felt Prestige in Therapy Groups.**

The possibility of a contradiction between Principle No. 1 (cohesiveness and we-feeling) and Principle No. 4 (prestige value) may suggest itself to the reader. A differentiation is required between *reputed* prestige derived from social roles or abstract symbols (beauty, education, money, talent, skill, blue-blood) and a steady feeling of respect, deference and willingness to cooperate more with certain members in the group, rather than with others. While the socially derived prestige of the therapist and of certain patients makes it possible for them to influence

others initially, the strength of this influence soon changes with increased actual contact experiences, depending on the amount of felt prestige the holder of derived prestige will accumulate in the group. The distinction between derived and felt prestige is illustrated by the sexually attractive patients who usually have very high initial prestige. But they soon lose derived prestige and may fail to gain felt prestige when their actual sex experiences, attitudes, or symptoms of frigidity or impotence, as well as their defensive behavior in the group, expose them as psychologically actually unattractive. On the other hand, when esthetically or sexually attractive patients show improvement, they gain in group prestige quickly. They have a highly therapeutic-contagion influence through their attention to those patients who are very disturbed about their own felt lack of sex appeal.

In the relatively long and stable life of the therapy group, criteria for prestige change, not only in the direction away from sources of derived prestige but toward in-group sources of felt prestige. The criteria for in-group prestige also change, as they seem to depend on many factors, especially after achieving frank and freely associative, self-other observations on a "deep" level. Such an achievement represents locomotion and progress toward a relevant therapy value. This adds to the in-group prestige of a member, as we know from our studies of sociometric assessments (cf. Chapter 11).

Now we can state a corollary hypothesis: in order to be continually effective with older patients, the group therapist cannot rely in the long run on derived prestige. He must earn in-group prestige, and this he can achieve only when the members actually experience him as a helpful contributor to the group.

In order to behave according to this hypothesis, the group therapist must increase his knowledge as to what actually is "helpful" to the group. To know this, it follows that he would consult the group concerning his own role and most optimal contribution to the group. This is a restatement of the concept of "sanctioned authority" (Wilson, 1951), already referred to.

Principle No. 4, stressing the maintenance of high prestige for the effective exertion of influence in the direction of thera-



peutic behavior change, can be followed only when one knows what renders felt (not derived) prestige to the therapist or to any other member in the group.

Preliminary observations concerning in-group sources of prestige in therapy groups indicate that in addition to nondefensive communications, already mentioned, a second generic source of in-group prestige in therapy groups is, paradoxically, the demonstration of mental health: interpersonally constructive contact-operational efficiency, plus reflecting a genuine sense of ego-satisfaction, or what C. Bühler (1952a) terms "fulfillment." The genuinely warm and accepting person, even if he or she may be of low macrocommunity standing, perhaps an intellectually or sexually less stimulating individual, often has high *felt* prestige in a group. Such a person, especially if he is an explicit communicator, can have a tremendous influence on his co-patients, which may in effectiveness go far beyond that which any doctor-therapist can ever have because of his naturally lower degree of cohesiveness in his relationship to patients.

Of clinical interest is a third source of in-group prestige which derives from the factor of reality contact. As would be expected in a group of individuals struggling with maintaining efficient contact with realistic life possibilities, patients who have the tendency to tie the group down to earth (on the many occasions when the group is "carried away" by irrational emotions) earn relatively high prestige in the group, even though they may have other characteristics which at other times would relegate them to a low prestige position.

A negative source of in-group prestige, that is, behavior which lowers prestige, is the initiation of events leading to increased tension and anxiety. Serving repeatedly as the carrier of what Polansky, Lippitt, and Redl (1950a) termed "the contagious initiatory act" in tension and anxiety evocation, definitely reduces in-group prestige. In this connection, we have noticed a sort of "nuisance value prestige" which particularly difficult patients gradually earn. They complicate the group life with their lack of sensitivity to the needs of others. Slowly but surely, everyone in the group makes allowances for such patients, as if



to immunize themselves against their influence by placing them in categories such as "trouble maker," "naughty," and "bad boy." Such patients are found to "lead" the group into diversionary, nonconstructive paths. They are the "ill leaders" who are discussed in the chapter on group tensions. They sometimes succeed in upsetting the group to a point where it is emotionally too tense to manage the instigator, who may remain temporarily in control of a group in a state of tension.

Our observations have convinced us that the prestige of a group member often depends on the covert values and emotional needs of the group at the moment of an individual's behavior. When the behavior is suitable for instigating the kind of tension reduction demanded at a given moment or phase in the group life, then the instigating person gains prestige. Since clear knowledge at any given moment of the ongoing group needs is difficult for the patient-members to obtain, by virtue of their clinically demanded preoccupation with their own individual reactions, the group therapist usually comes closest to sensing the existence and the nature of group tensions. Communicating such recognitions of covert group tensions is experienced as relief and anxiety reduction by the patients. By fulfilling the role of an expert participant-observer who communicates his sensitive perceptions, the therapist can gain felt in-group prestige. The recognition of and the selective communication of group tensions is a major aspect of the dynamically oriented group therapist. This job is the most effective in-group prestige builder for the therapist. Some of the major covert sources of group tensions are discussed in the next chapter.

**Principle No. 5.** The fifth principle summarizes the group dynamic research findings concerning the position of the deviant. The principle reads, according to Cartwright (1951): ". . . Efforts to change individuals or subparts of a group which, if successful, would have the result of making them deviate from the norms of the group will encounter strong resistance."

Group dynamic studies show that under certain conditions individuals will change basic attitudes, will change their whole

personality in order to maintain membership in a group that is of vital importance to them. Cartwright (1951) reports the following background material:

During the past few years a great deal of evidence has been accumulated showing the tremendous pressures which groups can exert upon members to conform to the group's norms. The price of deviation in most groups is rejection or even expulsion. If the member really wants to belong and be accepted, he cannot withstand this type of pressure. . . .<sup>3</sup>

The tendency of groups to enforce majority norms on their memberships makes it imperative that therapy groups develop a norm in which great individual differences are permitted. The therapist must help the group to guard against the development of a rigid norm of conformity according to which everyone is supposed to exhibit certain behaviors and refrain from other behaviors. The tendency toward cohesion is partially behind this apparent need of the group to have simple norms of what is good and what is bad group membership. One of the important roles of the therapist is to be an initiator and gatekeeper of norms. He must help the group to find an expression of the wish for cohesiveness through working together on an in-group norm that allows for a wide range of individual differences.

The tendency, studied by Festinger and others (1950*b*, 1950*c*, 1950*d*, 1951), of members to establish social reality through using each others' behavior as reference points is a double-edged sword in group therapy. On the one hand, majority consensus as to the interpersonal effects a member's behavior may have on the group is a tremendously valuable diagnostic and reality testing device. On the other hand, it is a common observation that in the realm of ego-defenses, the individual person is the last to see the light. The group is much quicker to sense the basis of a member's personality difficulties, while he himself is slow and defensive. When the majority pressure becomes too forceful too quickly, it may increase, rather than decrease, the defensiveness of a new member.

From the point of view of the mental health goal of the group, every member is a "deviant." On the skill with which

<sup>3</sup> Quoted from *ibid.*, by permission of the publisher.

the therapist handles the paradoxical situation that arises in the therapy group, in which every member is a deviant from the basic values of the group (to be mentally healthy and interpersonally effective) depends the effectiveness of intensive group therapy programs.

A study of "drop-outs" reveals that their behavior previous to the "drop-out" was considered deviant in one sense or another by a majority of the group. Groups may put excessive pressure to change on a deviant; in response the latter may become resistant to the point of leaving the group (cf. Festinger *et al.*, 1952). In mature groups, majority consensus concerning realities of any individual's behavior or "misbehavior" and unconscious motivations can be formed and maintained alongside a high tolerance for the ego-defensive, "acting-out" needs of the individual involved. Here the therapist is the pacesetter, for he is the only member of the group professionally trained to assess the individual patient's power to absorb and "take" the pressure of the group consensus.

In the final analysis, it is this feature of the dynamics of the group—that they just will not let an individual stay neurotic, that they will never reinforce (while they may wait and tolerate) blindness, acting-out, and other ego defenses against self-realization—that gives potency to the group approach to psychotherapy. For, as we noted before, paradoxical as it may sound, any group of emotionally or psychosomatically disturbed people always forms a majority consensus in the direction of the mental health status that most of those forming the consensus seek, but do not as yet possess (Foulkes, 1948). The paradox resolves itself when it is realized that the majority consensus is formed with respect to an individual. It represents a group analysis by several co-therapists of one patient. This is a powerful tool of psychotherapy: the need and wish to maintain, not only just membership, but high prestige membership in the therapy group whittles down defensive resistances most effectively.

The individual patient defends against being prematurely traumatized by the group's pressure toward "deep" insight and mental health by relying on another group ritual, initiated by



the therapist, reinforced and carried on by the older, experienced members of the group. This ritual requires that every individual must examine and communicate his own motives for his particular contribution to the group consensus concerning any particular individual. Through self-examination all the contributors to the "reality" of group opinions reveal their subjective need to solve, at least in part, their own problems by exerting pressure and influence on one another.

In fact, the recognition of the nature of one's contribution to majority opinion is one of the most effective ways of revealing to oneself the nature of many previously unconscious personal needs. The recognition of personal motives behind contributions to the majority consensus leads to a differentiation between neurotic countertransference reactions of the deviant and constructive, insight-mediating group influences. Also of ego-protective significance to the individual is the fact that everyone is an analyst of everyone else. When on the receiving end of group pressure, the individual knows that a moment later he will be on the contributing side with regard to someone else's dream or interpersonal behavior pattern in the group. Being both active in attempting to influence others and passive in receiving their pressure insures everyone against anyone's exerting too much pressure or carrying too much weight. The therapist is in the unique position either to reduce or strengthen group consensus by sanctioning. As the group sanctions his interpretation, so can he give or withhold "expert sanctioning" of group consensus.

**Principles Nos. 6, 7, and 8.** The next three principles discussed by Cartwright (1951) deal with "the group as a target of change," rather than with influence on the individual to change his behavior. These principles describe factors of group dynamics which affect what one may clinically term the health of the group. Group therapy experience has taught us the value of paying close attention to the health or pathology of the whole group, as well as the adjustment of the individuals in the group.

Principle No. 6 states: Strong pressure for changes in the group can be established by creating a shared perception by mem-



bers of the need for change, thus making the source of pressure for change lie within the group.

Principle No. 7 states: Information relating to the need for change, plans for change, and consequences of change must be shared by all relevant people in the group.

Principles No. 6 and No. 7 emphasize the ideas of shared communications and of making everyone in the group explicitly aware of the psychological processes occurring in the group. These are basic procedural principles in psychotherapy groups. Newcomb (1950) has shown that much group pathology results from an avoidance of open and free communication of problems affecting the group. Problems of communication jams and withholding of communications arise in therapy groups when patients are unable or unwilling to verbalize and communicate what they may clearly or vaguely sense as some state of frustration or pathology in the group situation which needs change and correction. The flow of therapeutically beneficial self-other analytical communication exchanges between patients may be seriously impeded when the spontaneous concern with the here-and-now, latently present in-group problems which create group tensions remain unattended. Such a neglect may be due to a narrow and rigid "clinical" interest in "working on the individual" combined with a lack of training and perceptual acuity of group factors on the part of the therapist.

There are many in-group problems affecting the free flow of therapeutically effective types of patient-patient communication. Some of these are absenteeism, certain types of subgrouping which create isolates within the group, turn-over, suppression of criticism and hostility (especially against the therapist), violation of the in-group boundary, failure of effective tension reduction following anxiety-evoking group experiences, excessive majority pressure on nonconforming individuals, and lack of sufficient opportunity to assess the total group situation. In all these and other situations, which we either have already discussed or shall discuss in this book, communication blocks and low morale are always lifted when, with the therapist acting when necessary as an initiator, all group members share and exchange their

perception of the blocking situation. Such shared communication either leads to a better acceptance of a frustrating situation which is difficult to change or to the organization of group pressure toward making certain changes within its own life.

Too often and too glibly do some group therapists attribute all communication blocks to "resistance" caused in response to analytic pressures on the individual to change. It would be equally blind and clinically naïve to go to the other extreme and assume that all that may look like group pathology is caused by factors of group dynamics when, in fact, many anxieties and communication block problems in therapy groups result from the ego-defense resistance dynamics of each individual in the group (cf. discussion on resistance as a source of group tension in Chapter 17). An empirical differentiation between group dynamic and ego-resistive sources of group pathology can always be made when, as part of the group's norm, all members of the group concern themselves explicitly with all the various in-group developments that may affect their psychotherapeutic progress. Groups which meet as regularly as do psychotherapy groups can be relied upon to manage very intelligently whatever problems may arise within the group, particularly when the therapist himself is fully aware of the ongoing group dynamics. It is a common observation which can be made in any therapy group meeting that tensions are reduced and communication jams untangled when the entire group takes a little time out and pays attention to the nature of the in-group difficulty at hand.

Three basic principles in the clinical management of psychotherapy groups are in line with group dynamic principles No. 6 and No. 7: (1) group-centeredness as against leader-centeredness, (2) authority role determination and group-sanctioning of leader role, and (3) development and enforcement of norms by the group.

All three management principles facilitate the making of adjustive changes in the group life on the basis of patient participation. Such participation on the part of the patients in managing their own group is not only psychologically sound group management, but it is also clinically and therapeutically sound, for the patient's experiences in managing his group, in

sanctioning authority, in guarding an "individual freedom" norm, and the like, represent ego-strengthening rehabilitating processes.

Principle No. 8 states : Changes in one part of a group produce strain in other related parts which can be reduced only by eliminating the change or by bringing about readjustments in the related parts (Cartwright, 1951).

Principle No. 8 makes us conscious of the various possibilities of either productive or pathological effects of subgroup problems on the total therapy group. At times the therapy group substructures are extremely important to the stability and maintenance of the group. When there are changes in friendship coalitions, or even changes in "fighting pairs" (coalitions maintained for the purpose of aggression release), one can expect that the tension within the subgroups, due to their reorganization, will find a reflection in the heightened tension level of the whole group. We shall discuss subgrouping and problems of tension levels and their management in the following chapters.

## Chapter 20

### CLINICAL SIGNIFICANCE OF GROUP TENSION<sup>1</sup>

---

A dynamic characteristic of therapy groups, commonly recognized by all observers (Hobbs, 1951; Powdermaker & Frank, 1953; and others), is an almost dramatic, oscillatory rise and fall of anxiety and tension levels associated with certain repeatedly occurring overt themes, or more or less latent (covert) issues. These rises and falls in tension levels seem to have certain implications to the therapeutic management of therapy groups which we shall examine in this chapter. Tension is here thought of, in line with Lewin's concept, as referring to natural conditions of living human organisms, normal or abnormal, rather than only to pathological symptoms of unsuccessful strivings. With respect to the latter, an integration of observations by Rogers (1951) on threat, by Hebb (1951) on fear, and by Rollo May (1951) and Mowrer (1950a) on anxiety, shows that reduction or diminution of tension states is a major drive of man.

A major function of psychotherapy is to aid the human organism in effective ways of reducing and managing anxiety and tension-excitation. Consequently the group therapist's interest is turned to those factors in the group therapy process which increase anxiety in the individual. When this process occurs in several individuals collectively at the same time, it creates special problems in the management of "collective anxieties." The practice of intensive group psychotherapy provides an opportunity to observe closely the various forms and sources of anxiety. With respect to his inner, unconscious needs, the patient has to protect himself from anxiety which accompanies the

<sup>1</sup> Parts of this chapter were prepared for and presented at the 1952 meetings of the Western Psychological Association in the "Symposium on Group Psychotherapy."



process of engaging himself and others in neurotic interpersonal contact operations, or what we have termed "set-up operations." Collective anxieties are instigated when the group discussion leads to the exposure of certain unconscious motives.

There is also a second source of anxiety for the individual members of the therapy group: group tensions. This additional source is endogenous to the group life and does not directly derive from the inner, personal dynamics of each member. Effectively functioning as a group therapist, therefore, requires keen judgment as to when the reflection and interpretation of "hidden agendas" and other group-endogenous sources of tension are helpful and relevant to a facilitation of the psychotherapeutic process in the individual.

Research by Powdermaker and Frank (1953) made it clear that a close, direct relationship between rise of tension levels in therapy groups and effectiveness of therapeutic experience of the individual exists. During extreme and rising tensions, patients are "closed," not open to participative communication or insightful observations. When tension levels are too high, therapy group members become irritable with each other and resistive to the therapist. Therapeutically effective tension management is therefore a technical necessity in group psychotherapy. It involves a full awareness and appreciation, not only on the part of the official therapist but also on the part of the other participants in the therapy group, of the effects of group tension and of ways of helping each other to relieve this tension.

The sensing by all patients of the interdependence of group life forces and their own behavior in the group is a part of the therapeutic experience that we help to provide for patients. We must, therefore, be able to understand as fully as possible these group tensions so that we may make interpretive observations of them.

### **Differentiation Between Collective Anxieties and Group Tension**

We are concerned in this chapter with an exploration of what these different additional and ahistorical kinds of unconscious

motivations might be, which in the group therapeutic situation color interpersonal communications, regardless of their overt content. In a dispositional way we have assigned to these "group-endogenous," unconscious motives the label "group tensions."

Our approach is differentiated from that of Sutherland (1952) and Ezriel (1952), who seem to assume that group tensions arise, like an algebraic sum, on the basis of each individual's having the same type of unconscious personal motive. For example, Sutherland (1952) describes how he would interpret a flirtation between two members in a group, not only in terms of the fairly obviously underlying sexual motives of each of the two participants, but that he would "emphasize why the flirtation had to be staged within the group and not outside." Sutherland then would interpret the need for sanction of the love-making by the whole group and go on to bring out the other members' unconscious fear of participating in the refusal to sanction or to disapprove.

This psychoanalytic group therapist might ascribe to such a refusal on the part of each individual in the group the significance that it constitutes an expression of "their fear of challenging this prototype of parental intercourse" (Sutherland, 1952). In other words, the group tension derives, for Sutherland, from the same types of unconscious motivations (in this case the transference of the fear of challenging the parental privilege of engaging each other in the primal scene) which determine the nature of communication and inhibition of communication in the free association type of verbal intercourse between individual doctor and patient. The only difference in Sutherland's point is that in the therapy group more than one or two people have the same unconscious fears and motives at the same time. By addition of similar unconscious motives, the "group tension" is created.

Our definition of group tension is reserved for something quite different. We do not deny the empirical validity of Sutherland's, Ezriel's, and Bion's observation that oftentimes several patients together elicit in each other similar unconscious fantasies concerned with the same aspect of private drives and

needs. But for this we would use the label "collective anxieties." The concept "group tension" does not derive from added-up emotional similarities in each patient. The concept of group tension is an "intervening construct" (Tolman, 1951) which refers to unconscious forces that are endogenous to the contemporary dynamics of the group life itself—the need to preserve and maintain the group in some state of equilibrium.

The author's differentiation between tensions of the group (tensions arising from the dynamics of the maintenance of the group's life and growth) and the simultaneous externalization of similar id-ego-superego components in several collected individuals is in line with the conceptual distinction between the group as an organism versus a collection of parts (Lewin, 1943*b*, 1944). Unresolved group tensions may have only an indirect relation to each individual's genetically conditioned emotional problems previously experienced in the two- or three-person psychology of his past infantile environment. Yet they unconsciously determine behavior, such as serious blocks in communication and group depression. These require elevation to conscious perceptual levels through the group therapist's interpretations in order to lift the tension.

Thus, when we compare, in the above example, the interpretation made by Sutherland and Ezriel with our interpretation, we would say that flirtation between two members, cited by Sutherland as an example, constitutes a threat to the balance of alliances in the group: the group is threatened by any sexual pairing because such pairing restricts freedom of movement within the group. It also would threaten to divert the work culture into a play culture. In adding our interpretation of group tensions to those suggested by Ezriel, we find that our approach affords more relief and insight into interpersonal adjustment problems of the patients, than does the Sutherland-Ezriel type of interpretation of collective tensions given alone.

### Maintenance of Social Fields and Equilibrium

Our rationale for the observation that patients obtain a relief from depression, through the understanding of their participa-



tion in group-endogenous sources of anxiety and tension, is that such understanding increases their feeling of ego adequacy and control. Such understanding helps them to build and maintain in real life, as well as in the therapy group, a field of interpersonal tension-release opportunities. Through observing how group tensions facilitate or block, or simply change the conditions affecting the maintenance of social fields which mediate the achievement of personal satisfactions, patients gain a new understanding of a stimulus area which they have heretofore been unable to sense, let alone perceive correctly.

In speaking of group tensions, we follow Lewin's definition of the group as a "dynamic whole," with each patient-member considered as an interdependent subpart in the sense that a change in the tension state (anxiety) of any member changes (to whatever degree) the tension state of any other group member. We posit, on the basis of experience, that all "established" therapy group members have certain minimal degrees of cohesiveness and closeness, which assure that minimal degree of interdependence necessary and sufficient to demonstrate that the boundary of the person is permeable. The individual is not an isolated personality structure. Lewin's (1935*a*) idea of the person as a field structure of interdependent tensions (each corresponding to various needs) can also be applied to the group where the different inner tensions are replaced by different individuals, each with his own inner tension system. Even though the individual patients' inner tensions must find expression, the cohesiveness of the group must not be upset beyond a certain point. In this connection, Bion (1949*b*, p. 296) speaks of a "balance of tensions . . . in terms of equilibrium between group mentality, group culture and individual."

### **Maintenance of a Communication Network in a State of Equilibrium**

The individual tends to act as if he is setting up for himself, maintaining, and improving a communication channel matrix which he can utilize for all kinds of drive-reduction purposes. Obviously, the fact that six to ten people in a therapy group are



doing the same thing at the same time forces us to assume a group frame of reference. We say: one of the group life characteristics is that the group behaves as if it creates and maintains a "communication network." The maintenance of any communication network is a source of group tension. One of the characteristics of the communication network is that it has a duration from birth to dissolution and that it attempts, during its lifetime, to maintain an optimal balance of reciprocal traffic of interpersonal messages. The network suffers as a whole when any part is disturbed. In this way individual tension and group tension are interdependent. The building and growth process of the communication network takes time, materials, and skill. The materials are the members, willing and able to fulfill certain roles. This creates a role repertoire, which the group wishes to preserve as completely as possible. Groups and individuals take time to work on the establishment of a communication network in a certain state which is governed by certain group norms. Under certain conditions (such as disturbance of an equilibrium) groups resist interruption, or dissolution; under other conditions they welcome changes.

Since Pareto's classical *Traité de sociologie générale* the concept of equilibrium has been used in the social sciences as an aid in analyzing the behavior of small human groups. This concept refers to the existence of a state of interdependence of parts of a system which behave in relation to each other as if they were under the control of some governing norm or force. Homans' definition of equilibrium may clarify the meaning of this concept as used by contemporary sociologists:

. . . A social system is in equilibrium and control, is effective, when the state of the elements that enter the system and of the mutual relationships between them is such that any small change in one of the elements will be followed by changes in the other elements, tending to reduce the amount of that change.<sup>2</sup>

Maintenance operations on the part of the group are clinically demonstrated by increasing group tensions that arise whenever change produces disturbances of the system beyond a certain

<sup>2</sup> From G. C. Homans, *The human group*. New York: Harcourt, Brace & Co., Inc., 1950.

minimum, for example, when the membership constellation of a group is changing, or when such change is suggested. Another example which will instigate the group's consolidation work occurs when one or more members deviate beyond a point from therapy group norms, as in the case of sexually acting out. The network maintenance by the group is analogous to the contact and social field maintenance of the individual. To draw the analogy to the individual further, Lewin (1951) postulated self-regulating processes in groups, referring to the tendency of groups to maintain a "quasi-stationary equilibrium" allowing for small, regular fluctuations, but compensating continuously for large changes and irregular disturbances in the group life.

As Homans (1950) noted, the tendency of groups to return to previous states, which is implied in the idea of equilibrium, makes the concept of equilibrium awkward for understanding the process of changes in states of group patterns from one phase to another. Growth changes are characteristic for successful therapy groups, which move in terms of changes in attitudes, activities, and even value system throughout the period of their lives. One of the major roles of the therapist as a leader of the group is to help the group to move from one social state to another through his influence and through the influence of the older patients, whom one may term in Homan's language, his "lieutenants."

Let us suppose, for example, that a therapy group gets "stuck" on the level of cathartic acting out of the conscious and unconscious emotional needs for aggression and sex release. Let us further suppose the hypothetical situation by which, say, through the clinical mistakes of the official conductor, or through his negligent defaulting, or through some external pressure or other factor, the group develops a standard or norm by which such acting-out behavior is considered the purpose of interaction. Realizing the trouble such a group is in, from a therapeutic standpoint, a therapist may now consult another leader to help the group to move into a new state. A certain minimal balance must be maintained in order that the system and communication network may survive the changes which may be brought about by the new leader's effort. The leader's effort to

change the group's state will be effective only if a state exists in which the elements who want to maintain the older state and thus revolt against leader pressures are balanced by other elements in the group who wish to reach the new state. The word balance is used to denote the state in which the changes can occur without the break-up of the system, as for example, an open revolt of the members not desirous of making changes leading to their leaving the group. Homans (1950) has given to this situation the term "moving equilibrium."

The above discussion clarifies an important function of therapy group management: the indication of a pattern for a group to follow in reaching a new state of affairs without serious disturbance of the existing communication network. An example of interest to us is the movement from a state of emotional tension and anxiety, which inhibits therapeutically helpful interpersonal communication, to a state of lowered emotional tension without inhibiting communication altogether or forfeiting the personal, nonstereotyped content of such communications.

Calling attention to and analysis of the manifest content of group discussion usually does not enable either therapist or group to work and move through situations characterized by strong group tensions. Ezriel (1950a) correctly observed that

. . . the manifest content of discussions in groups may embrace practically any topic . . . Whatever the manifest content may be there always develops rapidly an underlying common group problem, *a common group tension*, of which the group is not aware but which determines its behavior. [Italics mine.]<sup>3</sup>

An excellent example of the determination of manifest content by latent, underlying group tension is the unconscious avoidance of expressing values and opinions which may seriously isolate a member from the discussion. Even though the therapy group members belong to very different educational groups and have very different vocabulary repertoires, they will unconsciously select only words that are understandable to everyone. They will twist political and religious beliefs so as to maintain belong-

<sup>3</sup> Quoted from H. Ezriel, A psycho-analytic approach to the treatment of patients in groups, *J. ment. Sci.*, 96, 774-79, by permission of the publisher.



ing for themselves and prevent a split in the group. For example, in a group which contains both fertile and barren women, the fertile ones will repress discussion of their often very acute and intensely upsetting problems with their children on the basis of an unconscious fear that this may be a threat to the infertile members and thus endanger the cohesiveness of the group.

### Common Group Tensions and Individuality

The use of the word "common" group tension does not imply that everyone consciously or unconsciously experiences the tension in the same way. "Common" refers to the group frame of reference. For example, it is a common or total group problem when members split up into intensive subgroupings and pairings. In such a situation everyone can eventually perceive, through the therapist's help, the existence of a group problem, but each individual's reaction to it may be very idiosyncratic. While all members in such situations are affected by and concerned with a "common" problem, they may give very different expressions both to its original creation and to the attempt at solving the total group problem. In fact, it is this idiosyncratic, individualistic participation in the underlying group tensions, or what Bion (1948-51) has called the "valency" of a member, that makes it possible for group therapy to facilitate the understanding of individuality. It is a gross misunderstanding of the whole process of group therapy when it is believed that this process involves essentially a training of the individual to "adjust to" group standards. Actually, the process of participation, the formation of the group consensus, and the recognition of individual differences in such participation reinforce individual differentiation.

As far as the clinical management of therapy groups is concerned, the understanding of group tension can be summarized as follows: (1) identifying the forces that in an established group tend to change tension levels; and (2) studying the group's tendency to counteract and to defend against such changes in order to maintain a quasi-stationary equilibrium.

Studies of group dynamics in industrial work groups (cf. French, 1950; Trist & Bamforth, 1951) have brought to light



types of group defenses against crises produced by changes in the quasi-stationary equilibrium. For example, coal-miners may defend themselves against increased group-endogenous tensions by such devices as informal subgrouping; reactive individualism (deliberate isolation and refusal to communicate); displacement of aggression through mutual scapegoating; self-compensatory absenteeism, and other defensive reactions designed to reduce tension levels (Trist & Bamforth, 1951). In a similar fashion, group therapy participants will show defenses which represent adjustments to the here-and-now existing group tensions.

### Clinical Management of Group Tensions

Therapy group meetings are not simply entertaining or gratifying cathartic experiences for the participating patients. The experiences of gratification are outweighed by the more characteristic experiences of tension and frustration. According to Bion (1948*b*, p. 494):

The most prominent feeling which the group experiences is a feeling of frustration—a very unpleasant surprise to the individual who comes seeking gratification. . . .

. . . It is the nature of the group to deny some desires in satisfying others, but I suspect that most resentment is caused through the expression in a group of impulses which individuals wish to satisfy anonymously, and the frustration produced in the individual by the consequences to himself that follow from this satisfaction.<sup>4</sup>

One experiences a heightened sense of emotional tension in any group situation. In usual social settings the recognition of the source of emotional tension and frustrations, as well as observations of interpersonal techniques by which tensions are mastered, are complicated by repression of communication, stereotyped social reactions, and by social tact.

Intensive psychotherapy groups establish in regular, repeated meetings a high degree of cohesiveness. Cohesiveness and mutual good will make it possible to face the painful process of self-examination as to what or who causes tension, and what can or cannot be tolerated at the moment of tension. Awareness of

<sup>4</sup> Quoted from *Hum. Relat.*, 1, by permission of the publisher.

unconscious anxiety and tensions emerge which under usual social conditions remain either totally unrecognized, or, if felt, remain tactfully uncommunicated. The clearer recognition of sources of anxiety leads to attempts on the part of the therapy group to remove or to control them, or at least to protect itself against them psychologically.

A principle of group tension management which has been found useful in intensive group psychotherapy practice can be deduced from the above discussion: the group can tolerate higher intensity levels of emotional tensions than can the individual patient. In practice it can be repeatedly observed that suppressed and repressed attitudes and conflicts, which proved too disturbing to be borne by the individual without the mobilization of handicapping psychosomatic or acting-out defenses, can be faced and worked through when these same problems are brought into the open by the therapy group. All group therapists can verify Powdermaker and Frank's (1953) observation that groups have the potentiality for opening up the resistant patient's inner conflicts by providing him with the experience that in the intensive therapy group "underlying feelings would be more acceptable than his defenses" (Powdermaker & Frank, 1953, p. 254).

The tendency of therapy groups to "rally around" or to form group perceptions (consensus) on problematic issues of deep emotional significance to the individual members permits the uncovering of anxiety and tension-evoking materials in the group which the individual in isolation would keep suppressed or repressed. Thus, the arousal of rather intensive degrees of group tensions around certain emotionally significant issues is desirable from a clinical management standpoint. The arousal of optimal, not minimal, levels of tension permits the individual to bring into the open therapeutically significant unconscious material. The question of managing group tensions is one of better recognition of the antecedent instigators of group tensions and their therapeutic effect on the individual, rather than concern with keeping anxiety and tension levels always as low as possible, as seems to be recommended in the nondirective approach to group therapy (Hobbs, 1951).

The major technical function of the group therapist is to "move" the group and yet fulfill the group's need to maintain a communication network in an optimal state of equilibrium, including an optimal, which may not be a minimal degree of tension. In fulfilling the role of helping the group to maintain tension levels approximating the optimum for efficient functioning of the communication network, group therapists at this stage of technical development have three major procedures available to them: (1) attempting to select interpersonally suitable personnel (cf. Chapter 2); (2) acceleration and reinforcement in the evolution of a cohesive group culture, with a group-sanctioned value system assuring maximum freedom of individual locomotion without group disruption; (3) assisting the group, through interpretation, to gain insight into the "hidden agenda," or the "unconscious group emotions," or the morale state of the group, or the largely unconscious "group tension." Clinical experience has shown that in the individual, excessive degrees of tension are reduced to manageable proportions in part through recognition and insight into previously unrecognized sources of anxiety. As Krech and Crutchfield (1948) have pointed out, group tensions are resolved, at least in part, by the same procedure: a clearer recognition of the nature and antecedent instigation of tension.

Thus, the recognition of sources of group tension and their management are an essential part of the technical skill and knowledge of the group therapist, because he is the natural and often the only person in a therapy group to function in the role of observer, reflector, interpreter, and information-giver concerning underlying group emotions and tensions. This concern with anxiety and threat evocation, especially in terms of self-protection from anxiety, is the concern of everyone in the therapy group. Yet the professional psychotherapist plays an important role in helping the group not only to protect itself from excessively intensive tension levels, but also in helping it to be able to face and to give full expression to latent issues that evoke tensions. This role of the therapist is sanctioned by his experience and skill in recognizing factors of group dynamics which instigate group tension. By virtue of this skill, he is the natural person to verbalize

and communicate to the group his perception "on the spot" of whatever factors instigate tension at the time.

The remaining chapters of this book are devoted to a search for a clearer recognition of what some of the major factors of group dynamics are which produce tension in intensive therapy groups. What kind of issues repeatedly increase tension levels? How do groups react to these tensions? What does the therapist do to help the individual utilize group tensions therapeutically? These are some of the questions which will occupy our attention in the next chapters.



## Chapter 21

### GROUP TENSIONS RAISED BY LEADERS AND BY ISOLATES

---

The division between leaders and followers in any human group is in a constant state of flux. The proper or improper fulfilling of leader roles is an issue that always evokes a certain degree of interest and tension in all human groups. This interest is intensified in therapy groups because of the fact, already discussed in Chapter 4, that the expert group therapist does not behave according to the stereotyped concept of the benevolent doctor, the expert authority and directive guide. The belief in the inevitability of having to assume a submissive follower role in relation to the definite and unchallengeable expert-authority of "the responsible doctor" is universal with all newcomer-patients participating in group psychotherapy. However, the majority of contemporary group psychotherapists do not behave according to this initial belief of their patients, who react in various ways to the experience of being frustrated in their understandable anticipation that a benevolent authority will actively provide guidance and direction.

The technique of contemporary group therapists to turn the dependency of the new patient largely onto the group (Foulkes, 1948) raises the tension level, for it upsets a common and usual method of creating a balance between leaders and followers: "Let the doctor be the leader and the patients be the followers." That there is, in all human groups and particularly in therapy groups, a primitive and basic tendency of the membership to divide itself into passive (following) and active (leading) roles is known from factor analyses of therapy group members' roles (Giedt, 1952). We recognize in this tendency of dividing leaders and followers an instance of the dynamics of maintaining a

quasi-stationary equilibrium. Tension arises when the equilibrium cannot be achieved in socially (culturally) expected ways. We shall now turn our attention to the conditions which make it difficult for groups to find and maintain acceptable equilibrium with respect to this balanced role distribution.

The role that therapy groups delegate to the practitioner is balancing the group situation to a point where quasi-stationary equilibriums are successfully maintained, and yet permitting the group to move from the follower state to a more autonomous state of peer culture. For example, in a group of extremely regressed, passive dependent catatonics, the maintenance of an active-passive balance requires a more active psychotherapist, as the experience of group therapists specializing with these types of patients proves (Joël, 1952; Powdermaker & Frank, 1953). With neurotic patients the therapist-leader can try more successfully to move the group from the leader-centered, dependent state to a group-centered, largely autonomous state.

The success of this attempt of the therapist to lead the group from a dependency or follower state toward this advanced, more group-participant state may show itself in the group's tendency to shut him out, to consider him as not being a part of the group. At such a point groups may use the very ideology of the therapist's nondirectiveness to make a group-centered, united stand against him. Bion (1948-51) observed that every attempt he made to get a hearing showed that he had a united group against him. This experience by Bion is shared by all group therapists who have succeeded in creating a peer-centered culture.

The clinical reason for the necessity of such a culture is the personal, exposing nature of member-member communication in therapy groups. It is well recognized by students of human group life (Homans, 1950, p. 438) that:

. . . Personal problems and social relationships are inherently hard to communicate. Man does not want to talk about them or he has no clear language in which to talk about them as he would for instance have a precise terminology for talking about a piece of machinery.

This concise statement of one of the dilemmas of all leader authorities when in social contact with followers outlines the con-

flicting task of the group psychotherapist (Homans, 1950, p. 438).

. . . Here then is the twofold problem of the leader (a) how to encourage his followers to talk about *anything* that is on their minds in (b) a situation that makes communication inherently difficult. [*Italics mine.*]

The exercise of leader-authority, even when used to "inspire" and "encourage" freedom of communication, would inhibit self-revelations, especially toward the therapist. It would encourage hardly disguised sadistic-analytical bickerings between members, each trying to outdo the other in being the most effective and helpful "analyst." Homans (1950, p. 439) has shown that "the greatest barrier to free communication between follower and leader is the leader's authority." He likewise states (1950, p. 437) that:

. . . Authority is a weighty thing, . . . it tends to cut down interaction between leader and follower and make the follower's attitude one of distance.<sup>1</sup>

There are then very clearcut and good reasons why psychotherapists who conduct therapy groups must deviate in many respects from the usual or popular conception of the role of a person in authority, which sociologists have summarized by defining a leader as "a person who gives orders and upholds a moral norm" (Homans, 1950). Only insofar as the moral norm that he upholds is a norm developed in the group and continuously sanctioned by the group, does the group therapist exercise authority in this popular sociological sense. His authority and leadership may rest on what superficially appears to be a paradox of failing to play the authoritative leader role initially expected of him. It takes patients a long time to experience and accept the fact that part of their therapeutic progress involves their working through their authority problems. This would be impossible if the therapist failed to hold back "the weight of his authority."

The major point is: group tensions arise when either dependency needs or the need to have an active-passive balance is

<sup>1</sup> From G. C. Homans, *The human group*. New York: Harcourt, Brace & Co., Inc., 1950. Three excerpts, quoted by permission.

sought by one of several possible paths. Unlike any other human group leader, the trained group therapist blocks this path by "defaulting" the stereotyped leadership expected of him. This, in fact, leads the group to seek the solution of the leader-follower problem along other paths: Any person who helps the group to master threats to the equilibrium is a leader at that moment. Group therapists may find it helpful to think of the leader position in a group at any time as a role through which the group delegates to one or more members, whom they are willing to follow, the functions of maintaining the group on a quasi-stationary equilibrium, while moving the group to new states (as, for example, from a leader-centered to a group-centered organization).

The antithesis of leadership (as a clinician, one is tempted to say the definition of "ill" leadership) is to influence the group toward disintegration of an equilibrium, or in another situation toward influencing the group not to move along a new path, to a new state required by what we may clinically call the state of health of the group. Because of the negative and positive transference dynamics, psychotherapy groups are filled with both ill and healthy leader role types so well described by Fritz Redl (1942). When "ill leadership" influences are in ascendancy, that is, when owing to personal neurosis and other factors, the present leader does not help the group to make the changes required by the group's state of health, emotional tension is high and therapeutic progress, sometimes even the total group existence, is threatened. At times, an inexperienced group therapist unwittingly carries an ill leader role, as when he is either too directly active, or when he is too rigidly nondirective, inactive, or group-centered. Direct, inspirational group therapy leadership is a dead issue in professional circles. Inexperienced group therapists, rather, tend to fall into the latter category of extreme nondirectivity, resulting from a misunderstanding of what Foulkes (1951a) has called "leadership by default." We shall deal with this example, rather than with the example of the tension-producing directive therapist who unbalances the active-passive equilibrium by his excessive or even neurotic need always to take an active part in the group.



The problem of leadership defaulting is intensified by the fact that in psychotherapy groups we deal with disturbed individuals who feel even more frustrated than the average normal individual would when the therapist uses his authority to deny the weight of his leadership and turns much of the responsibility for leadership back onto the group. Even old groups, who have met for more than three hundred times, have exceptional difficulty in adjusting to this peculiar refusal of an official leader to behave in a way, which at least in a stereotyped sense, would fulfill the dependency demands presumably inherent in doctor-patient relationships. Excessive intensities of group tension can be instigated by the therapist when he practices a naïve and faulty interpretation of the so-called "leader-defaulting" (Foulkes, 1951a) role. Powdermaker and Frank (1953) have observed that inappropriate passivity and leadership-defaulting is characteristic of inexperienced group therapists who, feeling guilt over their strong desire to lead, show a counterphobic defense of passivity. Another unconscious source of passivity in group therapists is clinical voyeurism which serves as a defense against an overwhelming need or wish on the part of the therapist to be himself a patient, "one of the boys," rather than to carry the responsibilities of appropriate clinical leadership. When group therapists instigate excessive tensions resulting from inappropriate passivity, the patients turn to one or more peers to supply the role neglected by the therapist.

### Endogenous and "Ill" Leadership

In the course of their development, groups learn to handle tensions evoked from upsetting the usual leader-follower balance (frustration of dependency needs). One way by which new and young therapy groups meet this frustration is to turn to any member who is willing to be a leader. Some patients are always ready to take this role, regardless of their lack of ability to lead. Such volunteers show their intentions at the first initial role-setting opportunity (Bion, 1948b).

. . . most groups, not only patient groups, find a substitute which satisfied them very well. It is usually a man or woman with marked paranoid

trends; perhaps if the presence of an enemy is not immediately obvious to the group the next best thing is for the group to choose a leader to whom it is.<sup>2</sup>

Unfortunately, however, upon further experience, this momentary "solution" of the leader problem turns out to be a pseudo solution. It is invariably the severely disturbed, authority-ridden, anxiety neurotics or the paranoid members in a group who, through setting their role initially as being aggressive and alert, offer the group the answer to their prayer for "leadership," but all the group actually gets is neurotic dominance. Groups will elevate almost any aggressive volunteer, however mentally ill, to endogenous leadership in the face of the defaulting leadership on the part of the therapist, if the reformation of the group's state of quasi-stationary equilibrium demands it. In therapy groups, and perhaps in all groups, only an emotionally disturbed person with an insufficiently developed reality sense and a narcissistic ego defense, will engage himself and others in the illusion that he as an individual can bring about an equilibrium through personal leadership. Sooner or later, depending on the effectiveness of the ill leader to keep the group in a dependency mood, groups discover that the maintenance of a leader-follower division and the reduction of certain dependency tensions entail too much sacrifice and tension. The group is again upset. Motivations for a "revolt" emerge, and the "ill leader's" neurosis is exposed. But often ill leaders are allowed to keep the dependency mood up to a point where they exhaust the group in the same way the Pharaohs exhausted the Egyptians by making them build pyramids.

The group therapist does the opposite. He tries to lead the group away from irrational dependency needs instead of catering to them. He does not encourage the group in what in daily social living would perhaps be proper, "expert" behavior, but what for the goal of group psychotherapy would be a misuse of him. In the course of further attempts to manage the dependency problem, therapy groups develop, with the help of the therapist, communication conventions and other rituals which permit the safe expression of dependency without the danger of exploitation

<sup>2</sup> Quoted from *Hum. Relat.*, 1, by permission of the publisher.

by ill leaders. This is insured in part by a minimum of dependency on any one leader. In this more advanced phase of group life development, the suppressed skills of various members are recognized and authority to lead in certain phases in which a member may have a particular skill is sanctioned by the group.

Eventually, the group members experience the advantage, to them, of the peculiar type of leadership exercised by the therapist. Then they can and will make the previously tension-provoking reorientation toward the conductor. However, the process by which a group achieves a low leader-tension state may travel a rough and winding path during which the group will try to have the therapist do the very things that man's age-long experience has taught him make good, authoritative leaders in action-groups in the community (cf. the eleven rules of good leadership provided by Homans, 1950).

### Tension over Isolates and Newcomers

Another major source of group tension and anxiety, especially in established therapy groups, has to do with the nature and quality of subgrouping, with its side effect of creating isolates. One of the knotty problems of group therapy arises from the tendency of any group to form an elite clique and exclude others. Subgrouping is a very interesting and socially significant phenomenon. The clinical implications of subgrouping will be discussed in the next chapter. Here we are concerned with possible traumatic effects of exclusion that "leftovers" (their own term) from subgrouping often show.

Patients do attract each other socially, but not to the same degree. To begin with, only mutually attractive patients will be open to each other for interactions. This invariably leaves some members out. In the formation of new groups the total group culture may for a long time be determined by the distribution and intensity of interpersonal likes and dislikes among the therapy group members. We have already noted in our discussion of group dynamic principle No. 2 (Chapter 19) the importance of the factor of personal liking in the efficiency of influence. In the formation of new groups, it often happens that initially



no one fits into anyone's usual social contact level, especially when the principle of heterogeneity of grouping together members of different social classes is observed. In such new group settings one can study the development of social liking from the starting point, in which liking is at a minimum because of the rather large gaps in social and economic class membership which may exist among group members.

The development of preferential liking is a selective process, which means that one or two members in the group discover to their dismay that no one in the group likes them the best or prefers them as subgroup partners. The creation of one or two isolates or leftovers arouses tension in the group. The group is aware of this tension, and noticing that there is a tendency for a nuclear clique, a social elite, to differentiate itself from a peripheral group of less popular members, the group immediately senses a source of tension, even a danger to its existence and its purpose. As a matter of fact, the therapeutic process may be seriously impeded because one then actually deals with a disrupted group, incapable of forming consensuses.

There are many ways in which the group spontaneously attempts to prevent the extreme isolation of any member in order to prevent tensions which arise whenever any individual becomes isolated from the nucleus. As an example of one of many of the group's techniques, we are presenting the following protocol in which the group tries to make use of a newcomer to solve, in this case unsuccessfully, a tension situation that arose from the existence of an isolate.

PROTOCOL No. 18: HOW THE GROUP ATTEMPTS TO  
USE A NEWCOMER TO SOLVE GROUP  
TENSION OVER AN ISOLATE

[Excerpt from forty-third meeting of Group II. Attended by four females and four males. The newcomer, M-F; the isolate, R-M.]

Therapist (turning to M-F): You had a different interpretation of your relative silence here and your greater communication at the post-session. Can you tell the group your interpretation of why you are more talkative at the post-session?



M-F (newcomer, who has said scarcely anything up to now; this is her first real participation): Yes, I can; I know that it is easier for me to talk to one at a time. I can watch one person's reaction better than that of a whole group and I can modify—control my remarks as well as my opponent if it looks as if I am making a fool of myself.

Several members (reassuring M-F): Yes, that's right. It is easier to talk to one person at a time.

Th.: I suppose that in the post-session you are concerned more with maintaining your social contacts and friendship with one another; and for this, it is easier and more efficient to talk in pairs, to talk to *one* person at a time.

O-F: That's true. When I am busy trying to seduce someone particularly, I work on him alone in the post-session, and stay quiet in the regular group meeting.

K-F: Are you afraid that someone may disrupt your contact?

O-F: Only if I would expose my feelings and wishes to have a closer relationship to the group, then the group has a chance to interfere. I would rather prevent that chance. So, to get back to M-F, I can see that it is not just George's [Th.] presence, but that *regardless of the therapist our social maneuvering is best done with one at a time.*

K-F: I still think she is afraid of George. She does not want to expose herself to the therapist. She feels safer without him.

M-F: I am a little confused now. I think you spend enough time with me. . . . Well, no, as a matter of fact, I like men who are, or at least appear to be, strong and effective in their work and their personal relations. I like to attach myself to a secure personality such as George has.

K-F: Oh boy, she is just like me—in love with an image, a superior knight in shining armor.

M-F: I have done this before—attached myself to someone whom I believe to be a very secure male.

Th. (noticing R-M's depression): R-M, how do you feel about this?

R-M (the potential subgroup or pairing partner of the newcomer): I hate it. It makes me very mad. It makes me mad that there are some guys who all they have to do is to be around and everybody wants to attach themselves to him, and I—I work my balls off and get nowhere with anybody.

P-M: Especially when you throw two insults in with each effort.

[Group laughter. R-M's hostile characteristics are generally recognized and often joked about. There followed a brief discussion about establishing the idea of the person to whom people flock without any effort on his part as a fiction—that every attractive person works on maintaining his social and emotional contacts in good order, and that thinking about the fictitious idol serves as a defense against creative concern with improving one's own "pick-up" value or social appeal. This discussion was mainly for the benefit of R-M because of his constant complaints about his lack of popularity, without insight into the cause-effect relationship between his shock-provoking behavior and his isolated social position.]

R-M: Touché, touché. I would like to get back to M-F. I am beginning to accept some of this. You all have been harping on this point long enough. I am beginning to accept it. But now let's get back to M-F.

L-M: Well, M-F expressed very well how she seems impressed with secure males. I think R-M would be voted among the most secure. Then—well, she may like him, make a friend of him.

[Several express doubt that L-M is that much interested in R-M.]

Th.: This is actually the third time tonight that L-M has tried to boost R-M's ego. [Th. describes and checks with group three previous instances.]

O-F: Yes, and I know *why* he does it. He wants M-F [the newcomer] to be nice to R-M.

Th.: Can you say more about that—how you feel about that?

O-F: I feel the same way. I feel bad about having been so critical and rejecting of R-M lately when he tried to be friendly.  
[Pause]

Th. (to O-F): And you hope that perhaps the newcomer could pay off your social debt to R-M, which you feel but which you cannot directly do something about.

O-F: Yes, that's it! I want M-F to be nice to R-M. Then *I* don't have to do it and don't have to worry about R-M's isolation. And that's the same social intent, why you, L-M, tried to get R-M declared the most secure.

L-M: It's true that I am indebted to R-M. He has made many overtures to me, which I have rejected and I know that he likes me and that I have not reciprocated. This has bothered me.

. . . Yes, this is very good—I make R-M more attractive to M-F. Then in this way I can pay off my feeling of guilt.

O-F: And M-F can, you hope, do the actual good work, the actual reciprocation for you.

L-M: Yes.

[Group laughter following insight]

Th. (to M-F): You see how you as a newcomer inherit the unfinished social accounts in this group?

M-F: Yes, I begin to see.

The above protocol is an example of the empirical meaning of a “social role gap.” Accumulated or “unfinished” emotional needs are open ends which the present grouping cannot fulfill or satisfy, yet which the newcomer has a chance to fill as a result of the present grouping. Unreleased, unresolved group tensions and the adjustment of the group to the newcomer determine the nature of the gaps; the capacity of the newcomer and the nature of his social assets are factors that may determine his ability to “fit” and fill the gaps.

### **The Group's Concern with the Newcomer's Role**

The group-centered atmosphere of advanced therapy groups is characterized by increased differentiation of subparts. The analysis of subgroups represents an expression on the part of group therapy participants of their partial awareness of this group growth process. While in the initial or leader-dependent phase these experiences express themselves in terms of a keen sensitivity to hierarchical relationships, in later phases of life in the therapy group the concern expands to include a keen observation of shifts in patients' roles. This general expansion of sensitivity from authority reaction to peer reaction and role observation is a therapeutically significant experience for all patients. In studying our “failure file,” we can detect that several patients over the years dropped out at the same point: the point at which they refused to make the switch or expansion of interest from authority dependence of unilateral transference to peer orientation or multi-lateral transference.

Among the many roles that the group exchanges their opinions and feelings about is the role of the newcomer.

### **The Newcomer as a Subgroup: Initial Role Setting**

We have already mentioned some of the dynamic problems of the group and of the newcomer. Here we should like to look upon the newcomer as making a disturbance to established subgroup structures. An established group may be likened to a fairly calm lake. The introduction of a newcomer or newcomers may be likened to the dropping of a stone into the water. It is interesting to observe in more detail how the splash that the newcomer makes gradually calms down, how he is integrated into the group structure. Such a study would reveal that the integration of a stranger always involves a potential pressure in the direction of regrouping in roles, in heterosexual pairings, in coalitions, and in habitual set-up operation partners.

The factor of group dynamics common to all newcomers has to do with their insecure group position and their need to do something about it. Some newcomers have a compulsive need to act out the painful task of confession, which was felt as an indispensable initiatory prerequisite to forming a new group. In our experience, only certain patients tend to give expression to their need to belong through initiatory acts in terms of confessions. We would rather say that all newcomers tend to fit as quickly as possible certain roles in the past of other members. They respond, as it were, to the need of the group to fill a place in the group's cognitive structure. Not only does a new member, but the old members wonder, "How will I fit?" "Where does he fit?" Newcomers unconsciously facilitate the answer to this question by setting roles themselves to which the group, as Leary (1946) has observed, responds quickly in stereotyped fashion. Thus, some newcomers will present an initial role of being very helpless and dependent. Others may wish to show the group that they are very advanced and closely identified with the therapist. Still others will advertise their efficiency in clinical analyses independent of the therapist. Again, a patient may more or less unwittingly set his or her role as being sexually very



amenable. Some will show that they are very shy; others that they are very friendly and soft; others that they are very hard.

Initial role setting by new members is a necessary defensive mechanism to the threat of early isolation. It is a way of fulfilling the need to do something effective about belonging. The other members of the group naturally respond, because they, too, need to incorporate the new member. They will at first accept him in the role which he wishes to portray. However, only in very insecure groups with a low level of cohesiveness, and which may not meet often enough or long enough, do the initial roles remain frozen. In the more cohesive groups the initial roles are soon forgotten or worked through and the newcomer is known by his natural, spontaneous behavior, rather than by any stereotyped label or category. It is, in our experience, a clinical mistake to assign too much projective significance to the type of role that is set early because of the peculiarly strong wish of newcomers to be perceived as belonging to the group. This initial behavior may perhaps be simply an expression of his way of adjusting to the particular situation of having to become integrated into a group.

Leary (1946) observed a tendency on the part of the newcomer to provide the group quickly with a role label of himself, which the group usually seizes upon. It is my interpretation that this quick role setting by the newcomer and this role accepting by the group is an expression of the need to re-establish an equilibrium or role structure to calm down the lake into an ordered state. Peculiarly intensive conflict arises, however, when the newcomer's early role setting, which all newcomers will do, is in the nature of setting a role that evokes anxiety in the group. Then there is much difficulty for a long time; sometimes such newcomers never get integrated into the group.

Here is an example of how the unfortunate effects of initial role setting were gradually worked out. This is the case of a young psychiatrist-intern, who came to the group for both personal therapy and training in the technique of group therapy. In voting for this newcomer, the group was first quite hesitant and had postponed the decision for some time. The group anticipated correctly that such a person would find it difficult to par-

ticipate in any role other than "playing doctor," and unfortunately when they finally did include this member, his mode of mastering his insecurity in the new group was to fall back on his prestige symbols. At the first meeting he spoke about "my patients" and how he treated them successfully in individual therapy. This set him up in the role of a therapist. Again the group initially, in spite of their earlier verbalized fears, accepted the initial role setting and made use of the interpretive contributions of the newcomer, which were often experienced as helpful.

The group, however, gradually sensed the defensive nature of this initial role. In this case, the newcomer himself responded slowly, but in the long run adaptively. He asked for many individual sessions to help him unfreeze the initial role of playing doctor, which in his case was reinforced by his daily clinical work. It took over one hundred meetings for this patient to relinquish the initial role. Part of the slowness of the shift was due to the fact that the group never completely rejected his contributions in the role of a therapist, for this patient was well trained, intelligent and perceptive, and had a very clear way of communicating. Had the group been less appreciative and tolerant of the initial role, the patient would have experienced more anxiety, but he would probably have made the role shift sooner.

The reader familiar with the dynamics of resistance in individual therapy will immediately recognize that the setting of an initial role has a resistive significance and that the abandonment of a rigid initial role is expressive of successfully bridging the initial resistance. In looking back, many patients laugh when they remember the initial role they played in the group. Advanced patients sense they no longer play roles, that they no longer participate "segmentally" in the group life. This transition from "role-living" to full ego-participation is an aspect of emotional learning during the psychotherapeutic process mediated through group participation.

Polansky, Lippitt, and Redl (1950a, p. 338) have contributed toward the clarification of the perceptual problems of strangers by studying new boys entering camp groups:

The new boy entering a group, for example, may want very much to get accepted, and may be very willing to be influenced by those group

members whom he perceives as central to the group. But, in the face of a lack of knowledge of who is really central, and what is really acceptable behavior here, he may be inclined to act conservatively until such time as the group picture is clearer to him. In such a case, he would probably wait with his behavior until approached directly.

An interesting additional possibility is that such a child is more likely to be a case of "echo" contagion. That is, he would not imitate spontaneously but only after the number of children who have already been affected by contagion seems to him adequate to show that the particular behavior is clearly group-accepted.<sup>3</sup>

From these and other studies it is quite clear that we can talk about a norm of newcomer behavior, perhaps in terms of "casing the joint" conservatively. Consequently, we can speak of neurotic deviations from this norm. But at the present time we need more information in order to make the best therapeutic use of the manifest adjustment to newcomer role which is observable in the group.

In addition to the above mentioned need of the group to structure the fit of the stranger into the group, every newcomer is a potential strengthener or weakener of already existing subgroup alliances. Consequently, reaction to the newcomer from the point of view of the group is a function of the security and stability that already present members feel with respect to their subgroup partners. Since in effective group therapy management, subgroups are kept on a very fluid level by the group, a new member always effects changes in subgroup structure. It is observed that the marginal persons in the group, the "leftovers," the sociometrically unchosen, i.e., the "isolates," make the greatest overtures toward the newcomer with the hope of gaining a needed ally, but most newcomers do not respond eagerly to this. They prefer rather to wait and to diagnose who is of central influence in the group and then try to become an ally of the central, influential members. Very soon after the entrance of the newcomer, hostility toward him is expressed not by influential in-group members, who usually are quite protective of the newcomer, but from the disappointed isolates, who, sensing the newcomer's preference for central persons, become hostile to him.

<sup>3</sup> Quoted from *Hum. Relat.*, 3, by permission of the publisher.



Nowhere else can one observe so clearly the predictive limitation of the personality structure reference than in attempting a prediction of the fit of a newcomer in a therapy group on the basis of his personality structure alone. Here the interdependence of personality and social field is clearly demonstrable. To date, we have carefully observed the adjustment of therapy groups to more than thirty new entrants as well as the adjustment of the newcomers to the therapy groups. We have available careful and complete personality measurements on each new member as well as recordings of his behavior during several early meetings.

An analysis of these data convinces one that the main factors which determine the reaction of a group, both overt and covert, to a new personality will depend upon the contribution that the newcomer can make or does make to the group life. To put it in other words, one should know what group needs exist, what "vacancies" in the social field exist. Then in order to make an intelligent prediction one should know whether the newcomer has the response potentiality to fill these vacancies. Newcomers are slow in sensing the group's need. If the group, after fairly patient observation, senses that the newcomer cannot fill the anticipative role, his entry into the group arouses more intensive group tension than when the newcomer is able to sense and to fill more of the group's anticipations.

A newcomer has little chance of being accepted in a group if there exists tension over isolates, which the group hopes will be reduced by the newcomer's getting interested in the isolates. Unfortunately, however, newcomers try to evaluate the situation to see which members of the group have the most prestige and then try to attach themselves to them, rather than to the isolates. In the long run the therapist and the most advanced, older members resolve the tension of the isolate by paying clinical and helpful attention to him.

We have repeatedly emphasized that majority consensus formation is one of the major vehicles of effective pressure in the therapy group toward therapeutic changes in the individual. A group that is disrupted in terms of too rigid isolation of "social undesirables" has much difficulty in forming clinically useful



group consensuses as compared with groups in which the social isolate problem is less acute. Because of these implications to the efficiency of therapeutic management, an understanding of group tensions aroused by differences in interpersonal belonging is helpful to the practicing therapist. Tension is aroused not by the fact of subgrouping per se, for in any group therapy regime subgrouping, or what Slavson (1950a) has termed "multilateral transference relationships," are the heart of group psychotherapy. Rather, anxiety is evoked through the presence of isolates and leftovers, who do not belong to any subgrouping and who, consequently, at every opportunity, make an attack on the existing structures which they feel have denied them entrance.

An immature and ineffective way of "managing" the type of group tension derived from subgrouping and cliquing is to attack the isolates directly. This situation reminds one of Festinger's studies (1952) showing that groups usually will put pressure on the deviant to conform, to become one of them. The attacks are of the nature, "Why aren't you more popular with us?" But the isolates are usually members whose personalities either present a threat to most of the other members in the group, or who themselves are threatened by the friendly approaches which anyone in the group may make toward them. The pressure technique is only a cathartic pseudo management of tension, which often has the clinically undesirable result of increasing tension in both the isolate and the group.

Another rather primitive and authority-dependent way for the group to manage its anxiety over isolates includes the promotion of a closer relationship between the isolate and the therapist to provide some anchor and outlet for the isolate. The most effective way is for the group to become more vigilant with respect to general sharing by way of communicating all that goes on in the subgroupings and cliques. Mature therapy group cultures find an interesting balance between a fairly high tolerance for mutually constructive interpersonal coalitions, while keeping a very critical eye on any subgroup activity which may increase anxiety and tension.

Through free communication, mature groups make sure that any unfulfilled contact need in the social field becomes known

to everybody. The keen interest and concern of experienced groups in shifts concerning interpersonal belonging between members make it very hard for cliques to erect or maintain non-permeable boundaries within the group. Knowing who needs whom for what helps everyone to find his interpersonal fit. Open communication of in-group affairs helps the isolate to discover a gap or need in the social field which he can fill. When this happens, his tension-evoking attitudes toward the group change and the threat level is lowered.

Our policy of encouraging socialization also helps to overcome the forming of cliques and the personal isolation problem. Under such conditions the formation of cliques can take place and the need for it discharges itself outside the clinical meetings, where the isolates can analyze it and give it perspective. Thus, the isolates become involved with analyzing the clique. In this way excessive formation of cliques can be worked through to a degree sufficient to prevent major experiences of isolation. In response to the minority analysis, the elite clique sees and becomes ready to fulfill its own needs for a cohesive total group and begins to give fuller attention to and include all members of the group. Observation of the elite by other members of the group, together with an analysis of the ever-changing social distances and movements within the elite clique, soon forces the elite to expand. In the next chapter on coalitions we shall attempt to explain why it is so important for patients to have allies in the group.

### **Distinction Between Social Isolate and Clinical Nonconformist**

In the previous section we discussed the group's management of an individual patient who did not accept group consensus pressures. In a sense, the patient who resists group consensus is at that point an isolate, a nonconformist at least clinically. We have studied the influence of the factor of social popularity or liking on both the intensity of group pressure to conform clinically and the individual's willingness to accept such pressure.

On the whole our observations are in line with results predictable from the application of group dynamic Principle No. 2 (Chapter 19), for we have found that the socially liked member is, first, given more therapeutic attention by the group majority than the social isolates are given, and secondly, the socially popular member is less resistive to group majority pressures on him to accept group opinion and/or to change therapeutically. We are drawing the reader's attention to this observation to emphasize the fact that the social dynamics of therapy groups and the clinical therapeutic processes are very intimately related to each other, and to establish once again the fact that social interaction between members does not represent a force antithetical to therapeutic efficiency. The point is that the group must be helped to manage constructively group tensions that are produced by the existence of trailing or isolated stragglers or "leftovers."

## Chapter 22

### SUBGROUPING AND MAJORITY CONSENSUS

---

So far we have written mostly about the therapy group functioning as a whole. That is, we talked about "the group," implicitly assuming that "it" functions as a totality. Our final chapter will describe situations in which less than 100 per cent of the membership of a therapy group share and participate in the same ongoing event. Difficulties inherent in the simultaneous functioning of the total membership stimulate the formation of subgroups. Subgrouping fulfills certain needs that the larger group cannot fulfill. Operationally there evolves a subgroup structure of friendship pairing, spontaneous coalitions, partnerships, and rival subgroups. Smaller subgroups (quartets, trios, and pairs), each having its own boundary and certain degrees of distance from each other, form for various periods of time. These subgroup formations represent, at times, a threat to the cohesiveness and unity of the total group. Since subgrouping can instigate strong group tensions, the psychological dynamics of intimate subgroup contact warrants close observation.

In order to grasp the clinical significance of the type of close contact that neurotic patients have with each other in the subgroups, it is useful to establish some general psychological functions of peer-associations.

#### Normal Use and Function of the Subgroup

Four normal psychological functions seem to underlie singly or together all intimate face-to-face interpersonal human contact. They are:

1. *Confluence*, a term suggested by Jung (1946), here defined as the tendency unconsciously to gear, control and change



personal behavior to fit the other person's approach or response in such a way as to make, maintain and cement contact, rapport, and communication and to avoid isolation.

2. *Release associations*, defined as contact maintenance affording mutual emotional tension release, such as in play, sports, and purely "social" activities.

3. *Coalitions*, defined as associations for the pooling of individual power and influence to be exerted in the direction of nonmembers of the coalition for any number of purposes beneficial to the coalition members, such as occur in productive work associations.

4. *Pairing*, defined as associations maintained for the reduction of sexual and propagative needs.

These four forms of regular interpersonal traffic, which we shall presently describe more fully, can be differentiated from other forms of associative contact, such as neurotic set-ups.

**Examples of Confluence.** The routine clinical practice of administering diagnostic tests in order to determine the type of therapy most suitable for a given patient is a happy opportunity to demonstrate that even in such a fleeting contact as occurs between psychodiagnostician and patient, the interpersonal, rapport factor is so potent as to change the test results significantly. The patient or subject gives a different picture, depending on this confluence factor. In practice, one can observe response variations resulting from the administrator's sex and personality, especially when the test material is of a projective nature which tends to control experiential or conscious factors. Research studies have established the fact that even in relatively transient contacts a confluence factor between two people can be demonstrated (Kelly & Fiske, 1951; Lord, 1948, 1950; Shapiro, 1950). It is obvious from these studies that the conscious or intended purpose of human contact fails to illuminate the nature of unconscious interdependence.

**Examples of Release Associations.** Jennings' (1950) suggestion of the concept of "psychegroup," while broader, encompasses the more specific examples of small groupings of friends, who maintain contact with each other to afford opportunities for

tension release in situations which are removed from the rather rigid role restrictions present when the individuals participate in groups that have specific public functions. Private release associations, especially between just two persons, afford a full expression of emotions. Such a two-group is not handicapped by the problems encountered in larger than two-groups, such as communication jams and the necessity for multilateral adaptation to others' simultaneous participation. In the former, emotions are more fully expressed, both in intensity and in variety of quality.

**Coalitions.** Coalitions serve to strengthen the contact operations of the partners vis-à-vis third and fourth parties, other coalitions, and the total group. One can postulate that the forming of coalitions represents a conscious or unconscious attempt to add to one person's power field another person's resources and social influences. Evidence for the unconscious, instinctual nature of these associative coalitions comes from the observation of group behavior in animals. Chickens (Levy, 1950) and dogs have been observed to "gang up" in pairs to defend territory against an intruder. In young children's groups, in adolescent gang formations, in the "buddy" system, and in business partnerships, we have examples of adding power fields to form a coalition that increases the individual's ability to reduce a threat in his adjustment to other individuals or larger groupings.

Intimate associative coalitions having the function of mutual addition of power are not restricted to the two-group, as sexual pairings, but may have any number of members. Such coalitions have a greater efficiency of influence on an individual. One can think of a majority consensus in the therapy group as a formidable power field created by addition of the potential influencing power of each individual making up the majority. Individual patients cannot long resist repeated pressures on the part of majority consensus and yet remain and feel a sense of belonging in the therapy group. This may well be part of the "secret" of the melting of patients' resistances in groups against viewing previously unconscious desires and attitudes.

**Pairing.** Pairing serves the instinctual sexual needs of the partners and the propagative needs of the group. In some therapy groups, especially where the therapist is thought of as a symbol of moral conscience and repression, the sexual motives of pairing activities are not clearly expressed. As a result, they appear to some group therapists as "unconscious." In our groups, the sexual aspect of pairing is freely admitted, dreamed about, and discussed. However this may be, conscious or unconscious, the sexual drive certainly occupies a central theme in the emotions of heterosexual pairing partners in therapy groups. This has also been the observation of Bion (1948-51).

The anatomical division of the sexes in the animal world betrays the fundamental biological breeding and rearing basis of pairing. Pairing is a regressive, family type activity designed to excite and fulfill the propagation aspects of living. But in order to fulfill the function of rearing during the long years of dependency, other growth needs of the human adult must be fulfilled. These are fulfilled by associative groupings of adult organisms regardless of sex. The main biological drives which pairing excites are confluent: the sexes become one in intercourse. The fetus and suckling is part of the mother until it loses its hanging-on grip and is partly pushed or weaned away from the parent, partly escapes and weans itself. It seeks associative activities, except when sexual contact needs drive the young back to pairing with one exclusively attentive and attending partner.

Anxiety and conflict are instigated either when the organism cannot fulfill his propagational, instinctual needs and/or when the fulfillment of the sexual-propagational drive involves such intensive and exclusive pairing that it isolates the partners from participation in the larger associative group.

### **Pathological Uses of the Subgroup: Neurotic Set-up Operations**

The dynamics of psychopathological interpersonal behavior can be reduced to two basic and interrelated psychoanalytic concepts: (1) wish fulfillment (mobilization and reduction of pri-

mary motivations), and (2) ego-defense (mastery, or avoidance of anxiety). When the neurotic patient first enters intensive psychotherapy, he has only the vaguest awareness (if any) of the repertoire of his mostly repressed and suppressed strivings (cf. Dollard & Miller, 1950). The new patient also fails to sense in any accurate way the pattern of what Sullivan (1949) has termed his "security operations," that is his ineffectual ways of going about seeking both satisfactions and mastery. Intensive psychotherapy involves discovery and increased awareness of both the wish-structure and the defense system of the self. The therapist and the patient must be given the chance for a demonstration of the existence and the nature of his wishes and his defenses. This leads the way to an understanding of the kind of situations and motives which evoke previously unconscious fears and anxiety. Behavior in intimate informal subgroupings provides an excellent opportunity for therapeutically essential confrontations and demonstrations of revealing repetitions and idiosyncrasies. The patients can show each other, with a minimum of authoritative, interpretative contributions from the expert psychotherapist, how their interpersonal conflicts and inner tension-evocations are a function of what we have called neurotic set-up operations. These are pathological injections into the natural and normal interpersonal traffic (confluence, release association, coalition, sexual-propagative pairing).

In their intimate subgrouping, especially in pairs and trios, group therapy patients have every opportunity to accumulate enough evidence and clues to have demonstrated to them, by their own compeers, the nature of their real wishes and their fears. This new information includes knowledge as to how the life the patient leads (as exemplified in the subgrouping activities) is in stark contrast to what he really wants to achieve and what his real psychological needs are. When, for example, an overtly defensive, overaggressive female's longing for submission to the male and for love is recognized by the group from her private projections (in dreams, drawings, slips) and when she can then also be shown that simultaneously with her strong love needs, she spoils all chances of ever fulfilling her wish by her here-and-now defensive, aggressive overt behavior toward a tenderly ap-



proaching male member of the group, then the group has started the patient on the long road of rehabilitative insight into her own personality.

Speaking more precisely, we can say that the neurotic set-up operations in which patients engage each other in their subgroupings arise from a simultaneous manifestation of the following five unconscious patterns of neurotic interpersonal relations: (1) *projections*, in the sense of attributing to other patients wishes and longings unconsciously harbored by the self; (2) *externalizations*, sensing "empathetically" the other patients' fears, conflicts and anxieties actually harbored by the self; (3) *distortions*, fixated identification of other patients as having a certain role or attitude toward the self; (4) *acted out transferences*, the tendency to treat the reality of another as a mental image, and as if the real persons behave like fantasy figures (mothers, fathers, brothers), either infantile or contemporary; this it is unconsciously hoped will permit the release of suppressed wishes; and (5) *acted out countertransferences*, the tendency on the part of the approached patient to respond in "dovetailing" fashion to the attempts made by others to have transference experience through him.

No therapist can fail eventually to recognize in every neurotic patient the items of the neurotic set-up operations occurring between members, described above. The patients themselves naturally do not label the details of their interpersonal acting-out patterns in these psychoanalytic terms. They use such sentences as, "You project your own wish into me," or, "You are setting this up in order to experience rejection," or, "You are constantly drawing criticism from him, you make him criticize you." The use of such sentences by the patients reflects their interest in and ability to gauge and sense neurotic set-up operations quite keenly. The intensive group therapy approach relies heavily on the patients' natural acuity in recognizing the attempts of other patients to make neurotic use of them. The opportunity to act out neurotic conflicts on one another brings the nature of a patient's defenses to light. The therapist's expert contribution is usually limited to integrating, summarizing, and rendering some depth and perspective to the group's theragnostic work.

### Clinical Functions in the Total Group vs. the Subgroups

The subgroup is a stage for catharsis and intensive acting out, while the whole group is primarily a stage for reality analysis (consensus formation) and total group pressure toward psychological change (ego growth). The emotionally involved and "neurotic" subgroup activities furnish grist for the mill of total group analysis and pressure toward therapeutic change.

It is not uncommon that partners, while functioning vis-à-vis each other in the subgroup, will stimulate neurotic behavior manifestations in each other, and yet when participating in the total group's clinical work will attempt to correct and change the very behavior pattern which they had invoked in themselves and in their partners while functioning in the subgroup. This process is like the two-group ongoings in early orthodox individual psychoanalysis, when the analyst would deliberately instigate neurotic transference reactions in his patients while at the same time analyzing the elicited behavior patterns with a view eventually to change them. The analogy, however, is crude and incomplete because "co-therapist-patients" are much more active and energetic in neurotic set-up operations, or in their mutual provocation of transference-neurotic behavior, than any trained individual psychoanalyst ever would or could be. The "co-therapist-patient," as an individual, is further differentiated from the professional psychotherapist by his emotional inability to function as a relatively detached representative of social reality.

The peer-therapist patient makes up for this deficiency by the use of sanction from the total group consensus of his interpretive and analytic work. Experience by patients in trying to function as individual co-therapists has taught them that their influence toward change is much more effective for those suggestions that are "touché" and sanctioned by majority group consensus, which, as we have seen, may be further strengthened by the therapist's concurrence with group consensus. The wish to help and to influence others and the experience that this wish, never easily fulfilled, is doomed to remain entirely frustrated unless peer-

influence is backed up by total group pressure is, in the author's opinion, one of the basic factors that naturally limits the effectiveness of the subgroup to fulfill the needs of its participants.

Because only the sanctioning of total group consensus makes individual peer-influence effective, subgroups never stray too far away from the total group life, unless the participants are really no longer interested in making use of the group therapeutically. In order to maintain value-relevant, therapeutically effective influence on subgroup partners, all important subgroup pressures are aired before the total group in the hope of turning such pressures into effective total group influence on behavior. Any attempt subgroup partners may make to influence each other directly without sanctioning by majority group consensus eventually and invariably leads to a dissolution of the subgroup. In other words, subgroups formed to evade the reality test of majority consensus are a form of resistance.

The need to try to obtain group sanction of individual patient-to-patient pressure also explains why, on the whole, "acting out" does not go to the extent that would traumatize patients. Traumatization can occur only at the hands of the total group consensus and then only if and when such a consensus is sanctioned by therapist concurrence. The need to bring emotionally important subgroup influence to the attention of the total group also explains why acting out hardly ever trespasses the rather conservative limits of ethical, normative behavior set up by therapy groups for their members. A patient rarely cheats or exploits another, either emotionally or materially, without having to face the prospect of total group analysis. As a result, serious "misdeeds" on the part of patients against patients hardly ever occur.

Through participation in subgroups all individuals obtain information relevant both to the gauging of their power status and to the strength of both friendly and hostile influences in the group. In view of the often highly threatening nature of total therapy group pressures, it is not surprising that each individual is interested in keeping himself posted as to how and where he stands with each member. Only active and continuous subgrouping affords the opportunity to keep unconsciously cued and alerted as



to the existing power situation in the group. As potential group sources of security or insecurity are unknown to the patients, they tend, partly out of common sense and partly because they are insecure personalities, to project more hostile power against them in the group than actually exists. As a result, friendly communication during the official therapy meetings in the office is often repressed or kept on a relatively more guarded level. Appreciating the part that subgrouping plays in the total group-instigated security or insecurity for the individual gives us a further theoretical basis for the inclusion and encouragement of social subgrouping and open communications between all members as a group therapy technique.

### Therapeutically Oriented Subgroups

While the trend of the subgrouping activities of new members is toward concentrating on living things in preference to concentrating on establishing reality and other clinically helpful attitudes, advanced members will spend much of their subgrouping time in serious and responsible ways, not unlike individual therapy sessions. In group-experienced patients, one can observe co-therapeutic alliances in which the partners have very strong influence on each other. The effectiveness of such influences results, in part, from the fact that such co-therapeutic pairing has a deep-rooted choice basis, for in the subgroup there is really no majority or reality pressure to be clinical. When such a clinical coalition between two advanced patients develops, it invariably involves a strong, mutual attraction, which is sublimated by the therapeutic-clinical influence that each partner attempts to exert on the other. Since personal liking is a factor that strengthens effectiveness of influence in the direction of change, one can observe that some of the most remarkable psychological changes and improvements come about through such sublimated, co-therapeutic pairing. However, the development of such pairing is possible only between advanced and therapy-experienced patients and then only after each of the partners has previously gone through a long period in which subgrouping was used for nonclinical or acting and living out purposes.



While the professional therapist will not or cannot participate in this individual subgrouping with patients in such a way as to act out all the basic and neurotic functions of subgrouping, other members of the group are able and willing to do so. If encouraged by a relevant norm of the therapy group, which the members themselves actively maintain and sanction, patients will give cues freely to each other as to how they are affected by each other. The role of the professional therapist usually rules out exposing all his own counter-emotions toward the contact operations and set-up operations of the patient. (Latest developments in psychoanalytic technique seem to require the analyst to communicate his countertransference reactions, a recommendation which has been made previously by Jung [1935].) The therapist's reluctance to give of himself is replaced by a genuine willingness to communicate and to share the self on the part of co-patients. At the same time group consensus insures analysis.

Subgrouping is especially pronounced and intensive in the social post-sessions, when groups meet without the therapist. Often it is in a subgroup of members who attract each other that patients will, for the first time, remove their resistances or blocks against free expressions of their buried feelings and wishes which they have kept from the group and from the therapist. It is in the friendship coalitions that they will first indicate their readiness to reveal to themselves and to the group their set-up operations, their strong neurotic or perverse feelings, and their hostilities. In turn, the coalition partner, usually of the opposite sex, serves as a particularly attentive catalyst, who not only indicates that it is safe to bring out these neurotic feelings, but who unconsciously invites them as a protection against actual sexual involvement. Reassurance is given by the therapist that it will be safe to share these feelings with the group and with him. In other words, it is in the peer-subgroup that the patient finds it safe to experiment with expressions of suppressed emotional feelings which would take him many months or years of working through with an individual analyst the great weight of whose authority makes it a fearful venture to reveal oneself fully.

Since sexual attention produces too much anxiety and too much conflict, analytic attention releases the heterosexual ten-

sions. This type of "sublimation" is, of course, one of the well-known unconscious bases for interest in individual psychotherapeutic work (Freud, 1940). Our point is that the co-therapist patient can utilize the dynamic situation for therapeutic purposes more easily than can the professional healer alone. Working and living through intensive neurotic pairing has deep emotional effects of therapeutic significance. There is, first of all, concentration in time-space, and the benefit of continuous analysis. Furthermore, there is now little need for dangerous acting out, outside the therapeutic setting. For example, such intimate problems as frigidity of the nymphomaniac type (Bergler, 1951) need no longer be acted out by analytically stimulated divorce, but can be worked through in intensive group therapy within one or two years. The most "private" sensitivities are learned, recognized, and accepted, either as normal personal characteristics, or as neurotic methods of defense against deeper conflicts.

### Subgrouping as a Release Device

Fritz Redl (1944) has noticed a possible defensive effect of absorption in the pair or subgroup as an insulation against adjustment to the total group. Such insulation is often temporarily needed when full participation in the larger group evokes too much anxiety for the patient. Some subgrouping can be understood as a tension releasing device.

**Individual Sessions with the Therapist.** Since in our practice many of our patients are also seen individually, we can, from the point of view of the total group, say that these individual therapist-patient meetings fall into the category of subgrouping. How do the patients make use of this subgrouping? We have already noted in Chapter 5 that our individual meetings naturally center on particularly intensive emotional experiences triggered by the group. In the individual sessions the patient will rehearse and elaborate on these experiences. In this "close up" view the patient will give fuller expression of feelings which were lost in the rapid tempo of group communication or which he feared to communicate to the group as a whole. The patient

may add extragroup experiences from his present or past life which had similar emotional qualities. He senses repetition and gains perspective which facilitates the closure and integration of new self-discoveries to which he was originally alerted by majority group reactions to him. Some group-resistive patients will, of course, attempt to make use of this subgrouping to circumvent deep emotional participation in the total group. In some cases this "drainage" represents a form of resistance, a defensive protection against the influence of the group toward change. In other cases, the apparent tendency to dissociate the total group experience is a manifestation of the unconscious attempt to engage the therapist in such neurotic set-up operations as to gain a "favored son or daughter" or "buddy" or "assistant" position in the group.

The therapist must confront and interpret these interpersonal attitudes and work them through with the patient. The technique for this working through involves encouraging the patient to bring the experiences he had with the therapist during his private sessions to the analytic attention of the total group under the same principle which requires sharing with the group all emotionally significant subgroup experiences encountered with patients. Because of our method, patients come to see the therapist, as well as any other subgroup partner, as part of the total group. Still another way in which patients make use of subgrouping with the therapist can be seen in the expression of suppressed affection and hostility vis-à-vis other patients. This is parallel to the release of hostility toward the therapist, which occurs fairly regularly in the patient-with-patient subgrouping. The absence of the object of love and hate makes it easier to communicate and abreact some of these fear-evoking emotions.

Therapy groups assume and consider the therapist to be an outsider to the group. A therapy group will not include a therapist as part of itself. He is considered as a special subpart not subject to the rule of free expression of his innermost feelings, for he is given the privilege of maintaining his own discretion as to when to give or withhold personal reactions. In our regime, the question whether and to what extent the therapist should participate in a free expression of his own personal emotional experi-



ences, feelings, dreams, and associations comes under the principle of group sanctioning of an authority role. The decision of advanced groups in this respect usually arrives at this attitude: no one can insulate himself in the group without special effort. Some person in the group must keep most of his personal problems out in order to be able to make the special effort necessary to facilitate the communication of the rest of the group in a procedural way. For this special role the therapist is best fitted by skill and training and by his less acute need to interact for his own therapeutic purposes. The group agrees that these should be secondary or should be solved elsewhere. At the same time, advanced groups feel that the therapist, in his role as an example (perhaps not even as a good example), should answer honestly if and when group members are interested in his feelings or opinions at the moment.

In individual sessions the patient unconsciously shows his confluence tendency. He very ingeniously gears communications in such a way as to fill unwittingly the opening that the therapist offers. The type of opening is usually considered to be a function of the therapist's training and his "personality." More specifically, this must mean the therapist's method of defense against the basic assumptions underlying his pairing. The patient attempts to establish as broad a ground as possible for the pairing operation, but the therapist usually tries to limit these operations to a few regions of activity which represent his defense or mastery of the pairing, and which he has rationalized as being proper.

Experience with both individual and group therapy shows that the concomitant use of the group and individual therapy helps to work through more smoothly and to interpret with less resistance the unconscious set-up (transference) phases of the therapist-patient relationship. Sharing the therapist with the total group speeds the assumption of the constructive associative coalition phase. The reason for this advantage lies in the dynamics of patient-patient subgroups. Patients lend themselves naturally to all phases of subgrouping, while the professional therapist is capable of participating in only one—the coalition phase.



**Subgrouping with Individual Patients.** Except for gaining perspective, closure, and integration, the patients fulfill in patient-patient subgrouping the same needs as they attempt to fulfill in individual emotions involving the therapist. Gaining perspective, closure, and integration, however, requires the exclusive attention of a trained therapist not engaged in neurotic dovetailing responses to the patients' set-up operations. In the absence of intensive countertransferences and being able to draw from his experience and training, the professional therapist is in a superior position to cue the patient effectively in the necessary work of cognitive restructuring of the self. But as far as affording tension release, initial insight into set-up operations, and stimulation and pressure toward therapeutic change are concerned, subgrouping with co-patients is a more appropriate setting than the individual sessions with the therapist. In pairs, trios, and quartets patients may most freely discuss and give vent to their feelings concerning those not now participating in the subgrouping. This drains a great deal of clinically unconstructive tension from the total group meetings which can under such a regime be more fully devoted to relevant clinical work. Often these cathartic functions of the patients' subgrouping are combined with preparatory work for the later formation of total group consensus, which establishes the social reality for all analyses of individual patient's behavior and motive patterns.

**Recovery à Deux: Identification with a Pace-setter.** Social psychologists have observed that in "mutual best-friendships" a psychological symbiosis takes place. When group therapy was still very new we were concerned with the possibility, suggested by the phenomenon of *folie à deux*, that we might encounter mutual contagion between patients in the direction of identification with each other's psychopathology. It was soon realized that these fears were naïve and based on unsound assumptions. Alerted anticipations drew our attention to a new observation of patient-patient influence: we first noted that given members would watch with particular interest for progress along particular lines in one other particular person. Drawing the group's attention to this observation soon revealed that this was a general tendency in almost all patients. Each member in the group seems

to believe he had a pace-setter or "pilot" in another patient, who, having a very similar neurotic problem, seemed to be working on it successfully in a slightly more advanced stage than the watching patient. Patients are very keenly conscious of similarities in both problem and phase of progress in the problem.

We finally noticed that patients who feel that they share both the problem and (roughly) the phase of working through therapeutically move together or follow one another in short succession. As soon as the "pace-setter" has demonstrated a change in a given puzzling and stubborn problem, from which another patient feels he also suffers, then an initiatory act has taken place and the identifying patient gains the ego-strength to make his own move in a similar direction. This phenomenon of *recovery à deux* is particularly effective with respect to overcoming blind spots and blocks to threatening insights both into the structure of wishes and into the defense system. If Alpha can break through certain resistance phases, then Beta, provided he relevantly identifies with Alpha, will also break through. With respect to trying out new solutions after insights into newly discovered wishes and needs are integrated, the *recovery à deux* phenomenon has also been observed effective in the total and complex therapeutic process.

### The Aggressive-Submissive Peer Coalition

The total group is particularly interested in the many instances when one patient takes another unto himself in a mothering, hovering, protective, and advising manner. We have called such pairs leader-follower coalitions. The group is at first highly tolerant of the development of many of these until there has been enough opportunity to observe and detect the neurotic set-up nature behind these intensive leader-follower coalitions. This subgroup phenomenon represents very valuable material for theragnostic analysis (cf. Chapters 12 and 14). After several dozen meetings the group is in a position to detect characteristic cues in the choices of those who play either the follower or the leader role in these pairings. As a rule, every member except the extreme isolate has one or more running leader-follower

pairing roles at the same time. In the same pair the roles are reversible. It is not infrequent that one can observe that those who will take the dependent-follower role during the clinical session will have the courage to take the dominant-leader role in the more social post-session. The group, which is initially very tolerant of leader-follower pairings, is always on guard lest some of the more submissive and vulnerable members provide too much temptation to those neurotic members whose need is to incorporate and possess fully. In such cases, several members will make a protective link around the potential "victim" and prevent his being swallowed by the often very strong and compulsive needs of such neurotic "leaders."

Tensions and hostilities arise in this process. The role of the therapist in this instance is again to help the group understand the "hidden agenda," the underlying subgroup dynamic and ego-dynamic forces that make for momentarily acute tensions in the group. In helping to keep the group aware of its own subgroup processes, the therapist not only helps to keep anxiety and hostility on a bearable and manageable level, but he also provides the patient with a therapeutic experience of lasting value: The patient begins to realize his previously repressed interest in the many and varied subgroup and pairing phenomena in his present and early environments, such as the Oedipal trio. The patient begins to sense his interdependence with the relatively smooth functioning of these dynamics in all group living of which he may be a part, at work, in his past and his present family, and in the community.

### Sexual Pairing

All groups are concerned with the regulation of the sexual pairing activities of its members. Psychotherapy groups are no exception to this sociological fact. The situation becomes a problem that may impede therapy only when the therapist becomes too anxious in response to the relatively primitive expression of erotic attractions that patients may show (cf. Powdermaker and Frank, 1953). Actually, neurotic heterosexual groups are by no means licentious. The majority of the members of therapy groups are neurotic patients who often have strong feel-



ings of anxiety concerning sexual activity. A large number of patients, furthermore, have symptoms of impotence and frigidity, and many do not consider themselves desirable or adequate sexually. In addition to these general factors, which serve to inhibit actual sexual pairing, there seems to be operating a group dynamic factor, which is again in the nature of a group concern with anxiety levels and tensions.

It is tempting, in this case, to interpret the group's general concern with tension levels in terms of a reactivation of the incest taboo. The group senses from its own reactions even to semi-serious flirtations between group members that sexual excitation arouses strong anxiety and that such behavior increases the tension level of the group. As a consequence, the group is critical of anyone who contributes excessively to these tensions. Again, as we have seen in the case of anxiety-evoking roles, the group assumes that the therapist is vitally interested in maintaining the sexual acting-out taboo in order to keep tensions at manageable levels. This is a factor of group dynamics existing regardless of the therapist's actual attitude, for it can be found to operate within groups conducted by a great variety of group therapist personalities, ranging from very stodgy, moralistic individuals in a church setting to very "Bohemian" libertinistic therapists in an "artist colony." The differences in therapist-leader personality may show up in the value judgments about sex and behavior in general; but with respect to in-group ongoing, there is an almost basic understanding or convention to keep things on as low a tension level as possible not only with respect to sex but on all issues!

As can be expected, the danger of sexual acting out is strongest in newer groups and in established groups at the time a newcomer comes to the group. There are several very understandable reasons for this, one of which is the insecurity associated with the role of the newcomer. Newcomers, male or female, particularly if they have some confidence in their own sex appeal, are likely to attempt to use sex as a method to gain an ally in a strange group. In regressed schizophrenic patients open masturbation during the group meetings has been observed by Powdermaker and Frank (1953) as a psychotic defense against felt isolation.



Our neurotic isolates attempt to do something more directly social, such as flirtation when they are new to the group or when their position is threatened by the appearance of newcomers.

In principle, then, sexual pairing is attempted not only on the basis of lack of libido control, but as a reflection of the attempt to overcome an insecure position or role in the group. Whenever there are disturbances of the group role structure, one can expect flare-ups of attempts to act out sexually. On those occasions several patients may flirt with each other and again test their sex appeal as a means of testing their power and influence over each other. They will then openly express their desire for as well as their fear of sexual attractions and approaches. Almost everyone stops there. Let us try to be more specific on this point which seems to arouse so much professional interest on the part of individual therapists.

We made an observation concerning our two sample groups (which are two-sex groups) with respect to instances of actual sexual acting out between members. The extent to which these heterosexual groups of neurotic patients in intensive group therapy stimulated and led to sexual pairing was determined. The results of this study showed that the proportions of pairing which involved actual sexual intercourse were surprisingly low. The seventeen males and twenty females studied were observed to have had 153 pairing involvements, that is, manifestations of psychological interdependence and closeness. Between two opposite-sex members, only three of these, or 2 per cent, became involved in actual sexual intercourse. All other pairing fulfilled only leader-follower, coalitive, fighting, and other normal or neurotic set-up functions. This proportion of male-female pairing contacts in group therapy leading to actual overt sexual activity is probably lower than the proportion of such activity in social and working groups in everyday life with comparable opportunities.

A valuable cue for further understanding the inhibiting forces against sexual acting out was gained when the changes in the group status of three sexually acting out pairs, after they became intimate and gave active expression to the sexual phase, were noticed. First of all, the reaction by the group toward the women

was much stronger than toward the men. In each case the three female partners' reaction was discussed by the group as a manifestation of their resistance to therapy and their rejection of group standards. Each of the three females had a strong sexually tinged, positive transference attitude toward the group therapist, but since he failed to satisfy the latent requests of the transference neurosis, the positive transference turned negative. In such cases, it is natural that the female will turn to those male members in the group who appear to her to be rivals of the therapist-leader in the group. Thus, the displaced authority problems of the males and the, if you wish, transferred Oedipal problems of the female both dovetailed in a neurotic set-up operation, which *then* took the form of sexual intercourse.

That these unions were neurotic set-up operations was testified by the fact that they were fleeting, mutually anxiety-evoking experiences that, in retrospect, were seen as "neurotic" by the participants. It is well known to students of individual analysis that many female analysands go to bed neurotically with other men during a similar phase of their individual analysis, when their positive transferences take on a neurotic sexual tinge. With the group program such cases who fail to talk themselves through the transference neurosis in exclusively individual work are better able to work it through within the safe boundaries of the group therapy situation within a relatively brief period. Sexual transference neuroses, which are, of course, not completely avoidable in any method, are worked out in the safe and secret confines of the group. This protects the patient from realistic and irreversibly neurotic decisions in important life situations.

The fact that actual sexual pairing is openly interpreted by the total group as a resistance to therapy, and as a way of breaking with the group, demonstrates that groups can get away with effective interpretations of resistance in situations and cases where such interpretation from a therapist in individual settings would terminate the therapeutic relationship. The meaning of sexual acting out among members is openly discussed and its effects on the group culture, which is much more tolerant of leader-follower and coalitive pairings, and even of adverse pairings, are evaluated.

The group's keen attention to subgroup processes results in making everyone aware of how intimate involvements, be they sexual or excessive business or social involvement, handicap the participants with respect to permitting each freedom of communication of feelings in the group. Through experience or observation therapy group members come to the same understanding that prevails in the professional relationship between doctor-therapist and a patient in individual therapy: not to become too personally and socially involved in order to permit a free flow of ego-originating material. Close interpersonal involvement consumes the participants with maintenance of the involvements and inhibits in each participant the release of ego-originating forces. One of the roles of the therapist is to reinforce and to bring to fuller expression the group's good sense in this respect. As soon as the group senses that the threat to the group's locomotion toward its work goals, temporarily threatened by the seductive excitement of sexual pairing operations, has vanished, everyone settles down to make more constructive use of the group.





## BIBLIOGRAPHY

---

- ADLER, A. 1946. *The practice and theory of individual psychology*. London: Kegan Paul, Trench, Trubner & Co. (1st ed., 1925.)
- ALEXANDER, F., & FRENCH, T. M. 1946. *Psychoanalytic therapy*. New York: The Ronald Press Co.
- . 1948. *Studies in psychosomatic medicine—an approach to the cause and treatment of vegetative disturbances*. New York: The Ronald Press Co.
- ALLPORT, G. W. 1937. *Personality, a psychological interpretation*. New York: Henry Holt & Co., Inc.
- ANSBACHER, H. 1947. Adler's place today in the psychology of memory. *J. Personality*, **15**, No. 3, 197–207.
- . 1951a. Causality and indeterminism according to Alfred Adler, and some current American personality theories. *Individual Psych. Bull.*, **9**, 96–107.
- . 1951b. The history of the leaderless group discussion technique. *Psychol. Bull.*, **48**, 383–91.
- AXLINE, VIRGINIA. 1947. *Play therapy*. Boston: Houghton Mifflin Co.
- BACH, G. R. 1945. Young children's play fantasies. *Psychol. Monogr.*, **59**, No. 272, p. 69.
- . 1946. Father-fantasies and father-typing in father-separated children. *Child Developm.*, **17**, 63–80.
- . 1948. Theoretical and technical explorations in group methods of psychotherapy. *Amer. Psychologist*, **3**, 346.
- . 1950a. Dramatic play therapy with adult groups. *J. Psychol.*, **29**, 225–46.
- . 1950b. Towards a theoretical foundation for group psychotherapy. *Amer. Psychologist*, **5**, p. 470. (Abstract.)
- . 1952a. Some diadic functions of childhood memories. *J. Psychol.*, **33**, 87–98.
- . 1952b. (a.o.) Group therapy, a new setting for systematic research. A symposium. Proceedings, 32d annual meeting, West. Psychol. Assn. *Amer. Psychologist*, **7**, 535.
- . 1952c. Who are the discoverers of psychological knowledge? *Amer. Psychologist*, **7**, 131–32.
- . 1953a. A theoretical model for the group-psychotherapeutic process. Round table on group psychotherapy and psychodrama. Los Angeles: Program, 109th annual meeting, Amer. Psychiatric Assn.
- . 1953b. Forms of resistance against self-understanding in therapy groups. (Manuscript to be published.)
- . 1953c. Intelligence testing as an ego-mirroring technique in group therapy. Paris: Progr. XI Congres International de Psychotechnique, 11–12 (abstr.).

- BACH, G. R. 1953d. Technische und kulturelle Grundbedingungen für die Praxis der Gruppentherapie. Presented in Berlin, at the August meeting of the Ges. f. Psychiatrie u. Neurologie. (To be published in *Psyche*.)
- BACK, K. 1951. Influence through social communication. *J. abnorm. soc. Psychol.*, **46**, 9-23.
- BALES, R. F. 1950. *Interaction process analysis*. Cambridge, Mass.: Addison-Wesley Press, Inc.
- BALES, R. F., & GERBRAND, H. 1948. The "interaction recorder." *Hum. Relat.*, **1**, 456-63.
- BARKER, GENE. 1947. Interaction syndromes in the miniature psychodrama technique. Kent, Ohio: Unpublished M.A. thesis, Kent State University.
- . 1948. Experimental and clinical use of play-therapy technique in group therapy with neurotic and psychotic adults. Massillon, Ohio: Unpublished M.S. thesis, Massillon State Hospital.
- BARUCH, DOROTHY W. 1945. Description of a project in group therapy. *J. consult. Psychol.*, **9**, 271-80.
- BARUCH, DOROTHY W., & MILLER, H. 1949. Interview group psychotherapy with allergy patients, ch. 8 in SLAVSON, S. (ed.), *The practice of group therapy*, New York; Int. Univ. Press.
- . 1951. The use of spontaneous drawings in group therapy. *Amer. J. Psychother.*, **5**, 45-58.
- . 1952. Developmental needs and conflicts revealed in children's art. *Amer. J. Orthopsychiat.*, **22**, 186-203.
- BATESON, G. 1942. Social planning and the concept of "deutero-learning." In T. M. NEWCOMB & E. L. HARTLEY (eds.). 1947. *Readings in social psychology*. New York: Henry Holt & Co., Inc.
- BAVELES, A. 1948. A mathematical model for group structures. *Appl. Anthropol.*, **7**, 16-30.
- BERGLER, E. 1946. The danger neurotics dread most: loss of the "basic fal-lacy." *Psychoanal. Rev.*, **33**, 148-53.
- . 1949. *The basic neurosis*. New York: Grune & Stratton, Inc.
- . 1951. *Neurotic counterfeit-sex*. New York: Grune & Stratton, Inc.
- BERMAN, L. 1950. Psychoanalysis and group psychotherapy. *Psychoanal. Rev.*, **37**, 156-63.
- BETTELHEIM, B., & SYLVESTER, EMMY. 1947. Therapeutic influence of the group on the individual. *Amer. J. Orthopsychiat.*, **17**, 684-92.
- BIERER, J. (ed.). 1948. *Therapeutic social clubs*. London: H. K. Lewis & Co., Ltd.
- BION, W. R. 1948-51. Experiences in groups: I-VII. *Hum. Relat.*, Vols. 1-4.
- . 1948a. Experiences in groups: I. *Hum. Relat.*, **1**, 314-20.
- . 1948b. Experiences in groups: II. *Hum. Relat.*, **1**, 487-96.
- . 1949a. Experiences in groups: III. *Hum. Relat.*, **2**, 13-22.
- . 1949b. Experiences in groups: IV. *Hum. Relat.*, **2**, 295-304.
- . 1950a. Experiences in groups: V. *Hum. Relat.*, **3**, 3-14.
- . 1950b. Experiences in groups: VI. *Hum. Relat.*, **3**, 395-402.
- . 1951. Experiences in groups: VII. *Hum. Relat.*, **4**, 221-27.
- BION, W. R., & RICKMAN, J. 1943. Intragroup tensions in therapy, their study as the task of the group. *Lancet*, London, **245**, 678-81.
- BLAIN, D. 1949. Advances in group therapy. *Proc. Int. Congr. ment. Hlth.* Vol. III. New York: Columbia University Press.

- BOVARD, E. 1951. Group structure and perception. *J. abnorm. soc. Psychol.*, 46, 398-405.
- BRADFORD, L. P. (ed.). 1948. Dynamics of the discussion group. *J. soc. Issues*, 4, No. 2. Pp. 75.
- BROMBERG, W., & FRANKLIN, G. 1952. The treatment of sexual deviates with group psychodrama. *Group Psychother.*, 4, 274-89.
- BRONFENBRENNER, U. 1951. Towards an integrated theory of personality. Chap. viii in R. R. BLAKE & G. V. RAMSEY (eds.), *Perception—an approach to personality*. New York: The Ronald Press Co.
- BROWN, J. F. 1936. *Psychology and the social order*. New York: McGraw-Hill Book Co., Inc.
- . 1937. Psychoanalysis, topological psychology and experimental psychopathology. *Psychoanal. Quart.*, 6, 227-37.
- . 1953. *Psychodynamics of abnormal behavior*. (2d ed. in preparation.) New York: McGraw-Hill Book Co., Inc.
- BRUNER, J. 1951. Personality dynamics and the process of perceiving. Chap. v in R. R. BLAKE & G. V. RAMSEY (eds.), *Perception—an approach to personality*. New York: The Ronald Press Co.
- BRY, THEA. 1953. Acting out in group psychotherapy. *Int. J. group Psychother.*, 3, 42-48.
- BÜHLER, CHARLOTTE. 1933. The social behavior of children. In C. A. MURCHISON (ed.), *Handbook of child psychology*. Worcester, Mass.: Clark University Press.
- . 1953. Process organization and psychotherapy. *Psychiat. Quart.* In press.
- BÜHLER, CHARLOTTE, et al. 1952. *Childhood problems and the teacher*. New York: Henry Holt & Co., Inc. Pp. 372.
- BÜHLER, K. 1929. *Die geistige Entwicklung des Kindes* (The mental development of the child). (7th ed.) Jena: Fischer.
- BURCHARD, E. M. L., MICHAELS, J. J., & KOTOV, B. 1948. Criteria for the evaluation of group therapy. *Psychosom. Med.*, 10, 257-74.
- BURROW, T. 1927. The group method of analysis. *Psychoanal. Rev.*, 14, 268-80.
- CAMERON, N. 1951. Perceptual organization and behavior pathology. Chap. x in R. R. BLAKE & G. V. RAMSEY (eds.), *Perception—an approach to personality*. New York: The Ronald Press Co.
- CAMERON, N., & MAGARET, ANN. 1951. *Behavior pathology*. Boston: Houghton Mifflin Co.
- CANNON, W. 1945. *The ways of an investigator*. New York: W. W. Norton & Co., Inc.
- CANTRIL, H. 1949. Toward a scientific morality. *J. Psychol.*, 27, 363-76.
- CARTWRIGHT, D. 1951. Achieving change in people: some applications of group dynamics theory. *Hum. Relat.*, 4, 381-92.
- CARTWRIGHT, P., & ZANDER, A. 1953. *Group dynamics*. Evanston: Row, Peterson & Co.
- CHOWDHRY, K., & NEWCOMB, T. M. 1952. The relative abilities of leaders and non-leaders to estimate opinions of their own groups. *J. abnorm. soc. Psychol.*, 47, 51-57.
- COFFEY, H. S. 1952. Socio and psyche group process: integrative concepts. *J. soc. Issues*, 8, 65-74.

- COFFEY, H. S., FREEDMAN, M., LEARY, T., & OSSORIO, A. 1950. Community service and social research—group psychotherapy in a church program. *J. soc. Issues*, 6, No. 1. Pp. 65.
- CONANT, JAMES. 1947. *On understanding science: a historical approach*. New Haven: Yale University Press.
- CORSINI, R. 1951. On the theory of change resulting from group therapy. *Group Psychother.*, 4, 179–80.
- DALY, V. J. 1950. *Understanding mental illness (a patient's manual for group therapy)*. Whitfield, Miss.: Dept. of Publication, Mississippi State Hospital.
- DEMBO, TAMARA. 1931. Der Ärger als ein dynamisches Problem. *Psychol. Forsch.*, 15, 1–144.
- DEUTSCH, A. 1948. *The shame of the states*. New York: Harcourt, Brace & Co., Inc.
- DOLLARD, J., DOOB, L. W., MILLER, N. E., & SEARS, R. R. 1939. *Frustration and aggression*. New Haven: Yale University Press.
- DOLLARD, J., & MILLER, N. E. 1950. *Personality and psychotherapy*. New York: McGraw-Hill Book Co., Inc.
- DREIKUS, R. 1950. Techniques and dynamics of multiple psychotherapy. *Psychiat. Quart.*, 24, 788–99.
- . 1951. The unique social climate in group psychotherapy. *Group Psychother.*, 3, 292–99.
- DURKIN, HELEN E. 1948. The theory and practice of group psychotherapy. *Ann. N. Y. Acad. Sci.*, 49, 889–901.
- . 1951. The analysis of character traits in group therapy. *Int. J. group Psychoth.*, 1, 133–43.
- . 1953. Group psychotherapy and group dynamics. Panel on Group psychotherapy in private practice. 10th annual conf., Amer. Group Psychother. Assn., New York.
- ELLIS, A. 1949. Towards the improvement of psychoanalytic research. *Psychoanal. Rev.*, 36, 123–43.
- . 1950. Requisites for research in psychotherapy. *J. clin. Psychol.*, 6, 152–56.
- ENNEIS, J. 1951. The dynamics of group and action processes in therapy. *Group Psychother.*, 4, 17–22.
- EZRIEL, H. 1950a. A psycho-analytic approach to the treatment of patients in groups. *J. ment. Sci.*, 96, 774–79.
- . 1950b. A psychoanalytic approach to group treatment. *Brit. J. med. Psychol.*, 23, 59–74.
- . 1952. Notes on psychoanalytic group therapy: II. Interpretation and research. *Psychiatry*, 15, 119–26.
- FAIRBAIRN, W. R. 1943. The repression and the return of bad objects. *Brit. J. med. Psychol.*, 19, 327–41.
- . 1952. *Psychoanalytic studies of the personality*. London: Tavistock Publishers.
- FARBER, I. E. 1948. Response fixation under anxiety and non-anxiety conditions. *J. exp. Psychol.*, 38, 111–31.
- FEDERN, P. 1952. *Ego psychology and the psychoses*. New York: Basic Books.
- FENICHEL, O. 1945. *The psychoanalytic theory of neurosis*. New York: W. W. Norton & Co., Inc.



- FESTINGER, L. 1942. Wish, expectation and group standards as factors influencing level of aspiration. *J. abnorm. soc. Psychol.*, **37**, 184-200.
- . 1950a. The role of group belonging. Chap. iii in J. MILLER (ed.), *Experiments in social process*. New York: McGraw-Hill Book Co., Inc.
- . 1950b. Informal social communication. *Psychol. Rev.*, **57**, 271-82.
- FESTINGER, L., & THIBAUT, J. 1951. Interpersonal communications in small groups. *J. abnorm. soc. Psychol.*, **46**, 92-100.
- FESTINGER, L., BACK, K., SCHACHTER, S., et al. 1950. *Theory and experiment in social communications*. Ann Arbor: Institute of Social Research, University of Michigan.
- FESTINGER, L., SCHACHTER, S., & BACK, K. 1950. *Social pressures in informal groups: a study of a housing project*. New York: Harper & Bros.
- FESTINGER, L., et al. 1952. The influence process in the presence of extreme deviates. *Hum. Relat.*, **5**, 327-46.
- FIEDLER, F. E. 1951a. Factor analyses of psychoanalytic, nondirective and Adlerian therapeutic relationships. *J. consult. Psychol.*, **15**, 32-38.
- . 1951b. A method of objective quantification of certain counter-transference attitudes. *J. clin. Psychol.*, **7**, 101-7.
- FINK, D. H. 1953. *Be your real self*. New York: Simon & Schuster, Inc.
- FORER, B. 1949. The fallacy of personal validation. *J. abnorm. soc. Psychol.*, **44**, 118-25.
- . 1951. Experience with group psychotherapy. Personal communication.
- FOULKES, S. H. 1946. Group analysis in a military neurosis center. *Lancet*, London, **250**, 303-6.
- . 1948. *Introduction to group-analytic psychotherapy*. London: William Heinemann, Ltd. New York: Grune & Stratton, Inc.
- . 1951a. Concerning leadership in group-analytic psychotherapy. *Int. J. Group Psychother.*, **1**, p. 319.
- . 1951b. Remarks on group analytic psychotherapy. *Group Psychother.*, **4**, 56-59.
- FRANK, J. D., & ASCHER, E. 1951. Corrective emotional experiences in group therapy. *Amer. J. Psychiat.*, **108**, 126-31.
- FRANK, J. D., et al. 1952. Two behavior patterns in therapeutic groups and their apparent motivation. *Hum. Relat.*, **5**, 289-317.
- FREEDMAN, M., LEARY, T., OSSORIO, A., & COFFEY, H. S. 1951. The interpersonal dimension of personality. *J. Personality*, **20**, 143-61.
- FRENCH, J. 1950. Changing group productivity. Chap. vi in J. MILLER (ed.), *Experiments in social process*. New York: McGraw-Hill Book Co., Inc. Pp. 205.
- FREUD, ANNA. 1937. *The ego and the mechanisms of defense*. Trans. by C. Baines. London: Hogarth Press.
- FREUD, S. 1913. *The interpretation of dreams*. New York: The Macmillan Co.
- . 1914. *On the psychopathology of everyday life*. New York: The Macmillan Co.
- . 1922a. *Group psychology and the analysis of the ego*. Trans. by J. Strachey. London: Hogarth Press.
- . 1922b. Certain neurotic mechanisms in jealousy, paranoia and homo-

- sexuality. Chap. xiv in *Collected papers*, Vol. II. Pp. 232-43. London: Hogarth Press.
- FREUD, S. 1930. *Civilization and its discontent*. London: Hogarth Press.
- . 1933. *New introductory lectures*. New York: W. W. Norton & Co., Inc.
- . 1936. *The problems of anxiety*. New York: W. W. Norton & Co., Inc.
- . 1937. Analysis terminable and interminable. In *Collected papers*, Vol. V, pp. 316-57. London: Hogarth Press. (1950 ed.)
- . 1949. An outline of psychoanalysis. New York, W. W. Norton & Co., Inc. (First published in 1940.)
- FROMM, E. 1951. *The forgotten language*. New York: Rinehart & Co., Inc.
- GERARD, H. 1951. The effect of different dimensions of disagreement on the communication process in small groups. Ph.D. dissertation. Ann Arbor: University of Michigan.
- GIBB, J. R. 1951. The effects of group size and of threat reduction upon creativity in a problem-solving situation. *Amer. Psychologist*, 6, p. 324.
- . 1952. Effects of role playing upon (a) role flexibility and upon (b) ability to conceptualize a new role. *Amer. Psychologist*, 7, p. 310.
- GIBB, J. R., & PLATTS, GRACE. 1950. Role flexibility in group interaction. *Amer. Psychologist*, 5, p. 491.
- GIBB, J. R., PLATTS, GRACE, & MILLER, LORRAINE. 1951. *Dynamics of participation groups*. St. Louis: John S. Swift Co., Inc.
- GIEDT, H. F. 1952. Roles patients take in group therapy: a factor-analytic approach. *Amer. Psychologist*, 7, p. 529. (Abstract.)
- GOLDSTEIN, K. 1939. *The organism*. New York: American Book Co.
- GOODENOUGH, FLORENCE L., & HARRIS, D. B. 1950. Studies in the psychology of children's drawings: II. 1928-1949. *Psychol. Bull.*, 47, 369-433.
- GORDON, T. 1951a. Group-centered leadership and administration. Chap. viii in C. ROGERS, *Client-centered therapy*. Boston: Houghton Mifflin Co.
- . 1951b. Some theoretical notions regarding changes during group psychotherapy. *Group Psychother.*, 4, 172-78.
- GRABER, G. 1931. Neurotische Typisierung. *Int. Z. Psychoanal.*, 17.
- GRECO, M. 1950. *Group life*. Toronto: George J. McLeod, Ltd., Philosophical Library. Pp. xvi, 357.
- GROTTJAHN, M. 1950. The process of maturation in group psychotherapy and in the group therapist. *Psychiatry*, 13, 63-67.
- GUILFORD, J. P. 1950. Creativity. *Amer. Psychologist*, 5, 444-54.
- GUTHEIL, E. 1951. *The handbook of dream analysis*. New York: Liveright Publishing Corp.
- HAIGH, G. 1950. Multiple therapy as a method for training and research in therapy. *J. abnorm. soc. Psychol.*, 45, p. 659.
- HARLOW, H. F. 1949. The formation of learning sets. *Psychol. Rev.*, 56, 51-65.
- HARMS, E. 1948. Awakening into consciousness of subconscious collective symbolism as a therapeutic procedure. *Child Psychiat.*, 1, 208-38.
- HARRIS, H. 1949. *The group approach to leadership-testing*. London: Routledge & Kegan Paul, Ltd.
- HARROW, GERTRUDE S. 1951. The effects of psychodrama group therapy on role behavior of schizophrenic patients. *Group Psychother.*, 3, 316-20.

- . 1953. Modification of certain aspects of behavior of schizophrenic patients of psychodramatic group therapy. Los Angeles: Program, 109th annual meeting, Amer. Psychiatric Assoc., p. 64 (abstr.).
- HARTMANN, G. W. 1935. *Gestalt psychology*. New York: The Ronald Press Co.
- HASKINS, C. P. 1951. *Of societies and men*. New York: W. W. Norton & Co., Inc. Pp. xiv, 282.
- HEBB, D. O. 1947. Spontaneous neurosis in chimpanzees. *Psychosom. Med.*, **9**, 3-16.
- . 1951. The role of neurological ideas in psychology. *J. Personality*, **20**, 39-55.
- HEISE, G., & MILLER, G. 1951. Problem solving by small groups using different communication nets. *J. abnorm. soc. Psychol.*, **46**, 327-35.
- HEMPHILL, J. K. 1950. Relations between the size of the group and the behavior of "superior" leaders. *J. soc. Psychol.*, **32**, 11-22.
- HEMPHILL, J. K., & WESTIE, C. M. 1950. The measurement of group dimensions. *J. Psychol.*, **29**, 325-42.
- HILGARD, E. R. 1948. *Theories of learning*. New York: Appleton-Century-Crofts, Inc.
- HINKLEY, R. C., & HERMANN, LYDIA. 1951. *Group treatment in psychotherapy*. Minneapolis: University of Minnesota Press.
- HOBBS, N. 1951. Group-centered psychotherapy. Chap. vii in C. ROGERS, *Client-centered therapy*. Boston: Houghton Mifflin Co.
- HOGAN, R. 1952. A theory of threat and defense. *J. consult. Psychol.*, **16**, 417-25.
- HOMANS, G. C. 1950. *The human group*. New York: Harcourt, Brace & Co., Inc.
- HORWITZ, SELMA. 1944-45. The spontaneous drama as a technique in group therapy. *Nerv. Child*, **4**, 252-73.
- HULL, C. L. 1943. *Principles of behavior*. New York: Appleton-Century-Crofts, Inc.
- HULSE, W. C. 1949. *Psychohygiene und Gruppentherapie*. Die Psychohygiene, Medizinischer Verlag. Bern, Switzerland: Hans Huber.
- . 1951. Self-reporting in group psychotherapy. Annual meeting. Amer. Psychiat. Assn.
- . 1952. Chairman, Panel: Group psychotherapy in private practice. 9th annual conf., Amer. Group Psychother. Assn., New York.
- HUNT, J. McV. (ed.). 1944. *Personality and the behavior disorders*. 2 vols. New York: The Ronald Press Co.
- HUNT, J. McV., & SOLOMON, R. 1942. The stability and some correlates of group status in a summer camp of young boys. *Amer. J. Psychol.*, **55**, 33-45.
- HYDE, R. W., & SOLOMON, H. C. 1950. Patient government: a new form of group therapy. *Dig. Neurol. Psychiat.*, **18**, 207-18.
- JAHODA, MARIE, DEUTSCH, M., & COOK, S. (eds.). 1951. *Research methods in social relations*. 2 vols. New York: The Dryden Press, Inc.
- JAQUES, E. 1948. Field theory and industrial psychology. *Occup. Psychol.*, London, **22**, 1-8.
- . 1951. *The changing culture of a factory*. London: Tavistock Publishers.
- . 1953. On the dynamics of social structure. *Hum. Relat.*, **6**, 3-24.

- JENKINS, D. 1948. Feedback and group self-evaluation. *J. soc. Issues*, 4, No. 2, 50-60.
- JENNINGS, HELEN. 1950. *Leadership and isolation*. (2d ed.) New York: Longmans, Green & Co., Inc.
- JOËL, W. 1952. A method of group therapy with chronic "mute" catatonics. Unpublished paper delivered in the symposium on group therapy, 32d annual meeting, West. Psychol. Assn. *Amer. Psychologist*, 7, 535.
- JOËL, W., & SHAPIRO, D. 1949. A genotypical approach to the analysis of personal interaction. *J. Psychol.*, 28, 9-17.
- . 1950. Some principles and procedures for group therapy. *J. Psychother.*, 29, 77-86.
- JUNG, C. G. 1916. *Collected papers on analytical psychology*. Trans. by Constance E. Long. London: Bailliere, Tindal & Cox.
- . 1935. Grundsätzliches zur praktischen Psychotherapie. *Zbl. Psychother.*, 8, No. 2.
- . 1946. *Die Psychologie der Uebertragung*. Zurich: Rasher Verlag. Pp. 282.
- KELLY, E. L., & FISKE, D. W. 1951. *The prediction of performances in clinical psychology*. Ann Arbor: The University of Michigan Press.
- KELNAR, J. 1947. Treatment of inter-personal relations in groups. *J. soc. Issues*, 3, 29-33.
- KINGET, G. MARIAN. 1952. *The drawing completion test: a projective technique for the investigation of personality*. New York: Grune & Stratton, Inc.
- KLAPMAN, J. W. 1946. *Group psychotherapy: theory and practice*. New York: Grune & Stratton, Inc.
- . 1951. Group psychotherapy in institutions. *Group Psychother.*, 4, 181-96.
- KLEIN, R., & WANDER, E. 1933. Gruppenbildung im zweiten Lebensjahr. *Z. Psychol.*, 128, 257-80.
- KLEIN-LIPSHULTZ, EVA. 1953. A comparison of dreams in individual and group psychotherapy. *Int. J. Group Psychother.*, 3, No. 2.
- KNIGHT, R. 1949. A critique of the present status of the psychotherapies. *Bull. N. Y. Acad. Med.*, 25, 100-14.
- KOFFKA, K. 1935. *Principles of Gestalt psychology*. New York: Harcourt, Brace & Co., Inc.
- KORZYBSKI, A. 1951. The role of language in the perceptual processes. Chap. vii in R. R. BLAKE & G. V. RAMSEY (eds.), *Perception—an approach to personality*. New York: The Ronald Press Co. Pp. 170-205.
- KRECH, D., & CRUTCHFIELD, R. 1948. *Theory and problems of social psychology*. New York: McGraw-Hill Book Co., Inc.
- KRETSCHMER, E. 1949. *Psychotherapeutische Studien*. Stuttgart: Georg Thieme.
- KUBIE, L. S. 1941. The repetitive core of neurosis. *Psychoanal. Quart.*, 10, 23-43.
- . 1943. The nature of psychotherapy. *Bull. N. Y. Acad. Med.*, 19, 183-94.
- KUPPER, H. 1950. Psychodynamics of the intellectual. *Int. J. Psycho-Anal.*, 31, 1-10.
- LAWLOR, G. W. 1947. Role therapy. *Sociometry*, 1, 51-55.
- LEARY, T. F. 1946. The social dimensions of personality: group structure



- and process. Ph.D. dissertation. Berkeley: University of California.
- LEARY, T. F., FREEDMAN, M., COFFEY, H. S., & OSSORIO, A. 1951. Measurement of the group process and the nature of therapeutic improvement in group psychotherapy. *Amer. Psychologist*, **6**, p. 499. (Abstract.)
- LEAVITT, H. 1951. Some effects of certain communication patterns on group performance. *J. abnorm. soc. Psychol.*, **46**, 38-50.
- LECKY, P. 1946. *Self-consistency—a theory of personality*. New York: Island Press Co-operative, Inc.
- LEVY, D. 1939. Maternal overprotection. *Psychiatry*, **2**, 99-128.
- . 1950. The strange hen. *Amer. J. Orthopsychiat.*, **20**, 335-62.
- LEWIN, K. 1935a. *A dynamic theory of personality*. New York: McGraw-Hill Book Co., Inc.
- . 1935b. *Principles of topological psychology*. New York: McGraw-Hill Book Co., Inc.
- . 1937. Psychoanalytic and topological psychology. *Bull. Menninger Clin.*, **1**, 202-11.
- . 1941. Regression, retrogression and development. Chap. v in D. CARTWRIGHT (ed.). 1951. *Field theory in social science*. New York: Harper & Bros.
- . 1942a. *Field theory and learning*. In *41st Yearbook of the National Society for the Study of Education: The psychology of learning*. Chicago: University of Chicago Press.
- . 1942b. Time perspective and morale. In G. WATSON (ed.), *Civilian morale*. Boston: Houghton Mifflin Co.
- . 1943a. *The relative effectiveness of a lecture method and a method of group discussion for changing food habits*. Bull. III. Washington, D. C.: National Research Council.
- . 1943b. Psychology and the process of group living. *J. soc. Psychol.*, *SPSSI Bull.*, **17**, 113-31.
- . 1944. Constructs in psychology and psychological ecology. *Univer. of Iowa Stud. in Child Welfare*, **20**, 3-29.
- . 1946. Behavior and development as a function of the total situation. Chap. xvi in L. CARMICHAEL (ed.), *Manual of child development*. New York: John Wiley & Sons, Inc.
- . 1947. Group decision and social change. In T. M. NEWCOMB (ed.), *Readings in social psychology*. New York: Henry Holt & Co., Inc. Pp. 330-44.
- . 1948. *Resolving social conflicts*. Ed. by Gertrud Lewin. New York: Harper & Bros. Pp. 230.
- . 1949. Cassirer's philosophy of science and the social sciences. A chapter in *The philosophy of Ernst Cassirer*, ed. by P. A. Schlipp. Evanston: Library of Living Philosophers, Inc.
- . 1951. *Field theory in social science*. Ed. by D. Cartwright. New York: Harper & Bros.
- LIPPITT, R. 1949. *Training in community relations*. New York: Harper & Bros.
- LIPPITT, R., & REDL, F. 1950. An investigation of behavioral contagion in groups. *Hum. Relat.*, **3**, No. 4, p. 338.
- LIPPITT, R., & WHITE, R. K. 1947. An experimental study of leadership and group life. In T. M. NEWCOMB (ed.), *Readings in social psychology*. New York: Henry Holt & Co., Inc.

- LIPPITT, R., POLANSKY, N., & ROSEN, S. 1952. The dynamics of power. *Hum. Relat.*, **5**, 37-64.
- LOESER, L. H., *et al.* 1949. Group psychotherapy in private practice. *Amer. J. Psychother.*, **3**, 213-33.
- LORD, EDITH. 1948. The influence of negative and positive rapport conditions on Rorschach performance. Ph.D. dissertation. Los Angeles: University of Southern California.
- . 1950. Experimentally induced variations in Rorschach performance. *Psychol. Monogr.*, **64**, No. 10 (Whole No. 316).
- MCCANN, W., & ALMADA, A. A. 1950. A round-table psychotherapy: a technique in group psychotherapy. *J. consult. Psychol.*, **14**, 421-35.
- MCCARTNEY, D. 1952. The use of group psychotherapy in shortening individual treatment. 9th annual conf., Amer. Group Psychother. Assn., New York.
- MCCURDY, H. 1946. The history of dream theory. *Psychol. Rev.*, **53**, 225-33.
- MACDONALD, E. C., JR. 1951. The masking function of self-revelation in group therapy. *Int. J. group Psychother.*, **1**, 59-63.
- MCINTYRE, C. J. 1952. Acceptance by others and its relation to acceptance of self and others. *J. abnorm. soc. Psychol.*, **47**, 624-25.
- MAIER, N. R. F. 1949. *Frustration: the study of behavior without a goal*. New York: McGraw-Hill Book Co., Inc.
- MARTIN, E., *et al.* 1952. *Social skill hierarchy*. Mimeogr. Library, State Hospital South, Blackfoot, Idaho.
- MAUDRY, MARIA, & NEKULA, MARIA. 1939. Social relations between children of the same age during the first two years. *J. genet. Psychol.*, **54**, 193-215.
- MAY, R. 1950. The work and training of the psychological therapist. *Psychol. Serv. Center J.*, **2**, No. 1, 23 pp.
- . 1951. *The meaning of anxiety*. New York: The Ronald Press Co.
- MEAD, MARGARET. 1949. *Male and female*. New York: William Morrow & Co., Inc.
- . 1951. Group psychotherapy in the light of social anthropology. *Int. J. Group Psychother.*, **1**, 193-99.
- MILLER, H., & BARUCH, DOROTHY. 1949. Some paintings by allergic patients in group psychotherapy and the dynamic implications in the practice of allergy. *Int. Arch. of Allergy & Applied Immunology*, **Seperatum 1**, 60-71.
- MILLER, J. 1942. Unconsciousness. New York: John Wiley & Sons, Inc.
- . 1951. Unconscious processes and perception. Chap. ix in R. R. BLAKE & G. V. RAMSEY (eds.), *Perception—an approach to personality*. New York: The Ronald Press Co.
- MILLER, N. E. 1944. Experimental studies of conflict. In J. McV. HUNT (ed.), *Personality and the behavior disorders*. Vol. I. New York: The Ronald Press Co. Pp. 431-65.
- . 1948. Theory and experiment relating psychoanalytic displacement to stimulus response generalization. *J. abnorm. soc. Psychol.*, **43**, 155-78.
- . 1950. Some application of learning theory to psychotherapy. Symposium: Learning theory and psychotherapy. Los Angeles: University of Southern California.
- MILLER, N. E., & DOLLARD, J. 1941. *Social learning and imitation*. New Haven: Yale University Press.

- MONTAGU, A. 1950. *On being human*. New York: Henry Schuman, Inc., Publishers.
- MORENO, J. L. 1923. *Das stegreif theater* (Spontaneity Theater). Pottsdam: G. Kiepenheuer Verlag.
- . 1937. Interpersonal therapy and psychopathology of interpersonal relations. *Sociometry*, 1, No. 1.
- . 1946. *Psychodrama*. Vol. I. New York: Beacon House, Inc. Pp. 429.
- . 1952. Psychodramatic production technique. *Group Psychother.*, 4, 243-73.
- . 1953. *Who shall survive, foundations of sociometry, group psychotherapy and sociodrama*. Beacon, N.Y.: Beacon House, Inc. 763 pp.
- MORENO, J. L., & JENNINGS, HELEN H. 1934. *Who shall survive? A new approach to the problem of human inter-relations*. Washington, D. C.: Nervous & Mental Disease Publishing Co.
- MOWRER, O. H. 1948. Learning theory and the neurotic paradox. *Amer. J. Orthopsychiat.*, 18, 571-610.
- . 1950a. *Learning theory and personality dynamics*. New York: The Ronald Press Co.
- . 1950b. Identification: a link between learning theory and psychotherapy. Symposium: Learning theory and psychotherapy. Los Angeles: University of Southern California.
- . 1952. Learning theory and the neurotic fallacy. *Amer. J. Orthopsychiat.*, 22, 679-89.
- MULLAHY, P. (ed.). 1949. *A study of interpersonal relations*. New York: Hermitage Press, Inc.
- MURDOCK, G. P. 1949. *Social structure*. New York: The Macmillan Co. Pp. xvii, 387.
- MURPHY, G. 1947. *Personality: a bio-social approach to origins and structure*. New York: Harper & Bros.
- MURRAY, H. 1951. Toward a classification of interaction. Part 4, chap. iii, in T. PARSONS & E. SHILS (eds.), *Towards a general theory of action*. Cambridge: Harvard University Press. Pp. 506.
- NAUMBERG, MARGARET. 1947. Studies of the "free" art expression of behavior-problem children and adolescents as a means of diagnosis and therapy. *Nerv. ment. Dis. Monogr.*, No. 71, pp. xi, 225.
- NEWCOMB, T. M. 1950. Role behavior in the study of individual personality and of groups. *J. Personality*, 18, No. 3, 273-89.
- OBERNDORF, C. P. 1949. New possibilities in private psychiatric practice. *Amer. J. Psychiat.*, 105, p. 589.
- OVERHOLSER, W., et al. 1945. *Group psychotherapy: a symposium*. New York: Beacon House, Inc. Pp. 560.
- PHILLIPS, E. L., et al. 1951. The assimilation of the new child into the group. *Psychiatry*, 14, 319-25.
- PLANK, R. 1951. An analysis of a group therapy experiment. *Hum. Organization*, 10, No. 3, 5-21; No. 4, 26-36.
- POLANSKY, N., LIPPITT, R., & REDL, F. 1950a. An investigation of behavioral contagion in groups. *Hum. Relat.*, 3, 319-48.
- . 1950b. The use of near-sociometric data in research on group treatment processes. *Sociometry*, 13, No. 1, 39-62.
- POWDERMAKER, FLORENCE, & FRANK, J. 1948. Preliminary report of a re-

- search project of group psychotherapy. Washington School of Psychiatry, Mimeogr. Pp. 12.
- POWDERMAKER, FLORENCE, FRANK, J., *et al.* 1953. *Group psychotherapy—studies in methodology of research and therapy*. Cambridge: Harvard University Press. Pp. xv, 615.
- POWELL, J. W. 1948. The dynamics of group formation. *Psychiatry*, **11**, 117–24.
- . 1950. Group reading in mental hospitals. *Psychiatry*, **13**, 213–26.
- POWELL, J. W., STONE, A. R., & FRANK, J. D. 1952. Group reading and group therapy: a concurrent test. *Psychiatry*, **15**, 33–51.
- PRATT, J. H. 1908. Results obtained in the treatment of pulmonary tuberculosis by the class method. *Brit. med. J.*, **2**, p. 1070.
- . 1934. Influence of emotions in causation and cure of psychoneuroses. *Int. Clin.*, **4**, 1–16.
- RANK, O. 1947. *Will therapy and truth and reality*. New York: Alfred A. Knopf, Inc.
- REDL, F. 1942. Group emotion and leadership. *Psychiatry*, **5**, 573–96.
- . 1944. Diagnostic group work. *Amer. J. Orthopsychiat.*, **14**, 53–67.
- REICH, W. 1945. *Character analysis*. New York: Orgone Institute Press.
- REICHENBACH, H. 1951. *The rise of scientific philosophy*. Berkeley: University of California Press. Pp. 333.
- RICKMAN, J. 1950. The factor of number in individual- and group-dynamics. *J. ment. Sci.*, **96**, 770–773.
- RIESMAN, D. 1950. *The lonely crowd*. New Haven: Yale University Press. Pp. 386.
- RIOCH, JANET. 1949. The transference phenomena in psychoanalytic therapy. Pp. 80–97 in E. MULLAHY (ed.), *A study of interpersonal relations*. New York: Hermitage Press, Inc.
- ROGERS, C. 1951. *Client-centered therapy*. Boston: Houghton Mifflin Co. Pp. 550.
- ROSENBAUM, M. 1952. The challenge of group psychoanalysis. *Psychoanalysis*, **1**, 42–58.
- RUESCH, J. 1949. Individual social techniques. *J. soc. Psychol.*, **29**, 3–28.
- RUESCH, J., & BATESON, G. 1951. *Communication: the social matrix of psychiatry*. New York: W. W. Norton & Co., Inc.
- RUESCH, J., & PRESTWOOD, A. R. 1950. Interaction process and personal codification. *J. Personality*, **18**, 391–430.
- SARBIN, T. 1950. Contributions to role-taking theory: I. Hypnotic behavior. *Psychol. Rev.*, **57**, 255–71.
- SCHACHTER, S. 1951. Deviation, rejection and communication. *J. abnorm. soc. Psychol.*, **46**, 190–207.
- SCHIEDLINGER, S. 1952a. *Psychoanalysis and group behavior: a study of Freudian group psychology*. New York: W. W. Norton & Co., Inc.
- . 1952b. Freudian group psychology and group psychotherapy. *Amer. J. Orthopsychiat.*, **22**, 710–17.
- SCHILDER, P. 1936–37. The analysis of ideologies as a psychotherapeutic method especially in group treatment. *Amer. J. Psychiat.*, **93**, 601–17.
- . 1939. Results and problems of group psychotherapy in severe neuroses. *Ment. Hyg.*, N. Y., **23**, 87–98.
- . 1940. Introductory remarks on groups. *J. soc. Psychol.*, **12**, 83–100.



- . 1951. *Psychotherapy*. New York: W. W. Norton & Co., Inc. (Rev. ed.)
- SCHNEIDER, L. 1948. *The Freudian psychology and Veblen's social theory*. New York: King's Crown Press.
- SCHULTZ, J. H. 1950. *Das autogene Training (Konzentrierte Selbstentspannung)*. (6th ed.) Stuttgart: Georg Thieme.
- SEARS, R. R. 1944. Experimental analysis of psychoanalytic phenomena. Pp. 306–32 in J. McV. HUNT (ed.), *Personality and the behavior disorders*. New York: The Ronald Press Co.
- . 1951a. Social behavior and personality development. Part 4, chap. iv in T. PARSONS & E. SCHILS (eds.), *Towards a general theory of action*. Cambridge: Harvard University Press.
- SEARS, R. R., et al. 1951b. Memorandum on the concept of identification. Hum. Developm. Lab. Harvard Univ. Mimeogr.
- SELIGMAN, B. Z. 1950. The problem of incest and exogamy: a restatement. *Amer. Anthropol.*, 52, 305–16.
- SEWARD, GEORGENE, MORRISON, L., & FEST, BEVERLY. 1951. Personality structure in a common form of colitis. *Psychol. Monogr.*, 65, 1 (#318).
- SHAPIRO, D. 1950. A study of the influence of the social field on individual behavior: as revealed in the expression of hostility and warmth by neurotics and paranoid schizophrenics in discussion group situations. *Genet. Psychol. Monogr.*, 42, 161–230.
- SHASKAN, D. 1949. The function of the group. *Psychoanal. Rev.*, 36, 385–88.
- SHASKAN, D., et al. 1951. Prediction for behavior in group psychotherapy from Rorschach protocols. *Group Psychother.*, 3, 218–30.
- SHERMAN, M., & LINDT, H. 1952. "Social incognito" in analytically oriented group psychotherapy. *Int. J. group Psychother.*, 2, 209–20.
- SHNEIDMAN, E. S. 1948. Schizophrenia and the MAPS test. *Genet. Psychol. Monogr.*, 38, No. 2, 145–223.
- . 1949. *The make-a-picture story test*. New York: Psychological Corp.
- SLAVSON, S. R. 1943. *An introduction to group therapy*. New York: The Commonwealth Fund.
- . 1950a. *Analytic group psychotherapy*. New York: Columbia University Press.
- . 1950b. Bibliography on group psychotherapy. Group Therapy Brochure, 32. Amer. Group Ther. Assn., New York.
- . 1951. The dynamics of analytic group therapy. *Int. J. group Psychother.*, 1, 208–17.
- SOMMERS, VITA. 1953. Group psychotherapy with members of different minority groups. Paper delivered at 10th annual conf., Amer. Group Psychother. Assn., New York.
- SPEER, E. 1949. *Der Arzt der Persönlichkeit*. Stuttgart: Georg Thieme.
- . 1951. *Die Liebesfähigkeit, Kontaktpsychologie*. München: J. F. Lehmanns Verlag. Pp. 181.
- SPENCE, K. W. 1950. Theoretical interpretations of learnings. In S. S. STEVENS (ed.), *Handbook of experimental psychology*. New York: John Wiley & Sons, Inc.
- SPITZ, R. 1945. *The psychoanalytic study of the child*. Vol. I. New York: International Universities Press, Inc.

- STEINZOR, B. 1950. The spatial factor in face to face discussion groups. *J. abnorm. soc. Psychol.*, **45**, 552-55.
- STERNBACH, O. 1947. The dynamics of psychotherapy in the group. *J. Child Psychiat.*, **1**, 91-112.
- SULLIVAN, H. S. 1945. *Conceptions of modern psychiatry*. Washington: Wm. Alanson White Psychiatric Foundation. (Reprinted from *Psychiatry*, **3**, No. 1, and **8**, No. 2.)
- . 1948. The meaning of anxiety in psychiatry and in life. *Psychiatry*, **11**, 1-13.
- . 1949. Psychiatry: introduction to the study of interpersonal relations. Pp. 980-1211 in A. MULLAHY (ed.), *A study of interpersonal relations*. New York: Hermitage House, Inc.
- . 1951. The psychiatric interview. *Psychiatry*, **14**, 316-73.
- SUTHERLAND, J. D. 1952. Notes on psychoanalytic group therapy: I. Therapy and training. *Psychiatry*, **15**, 111-17.
- TAYLOR (F. KRAUPL). 1949. Experimental investigation of collective social and libidinal motivations in therapeutic groups. *Brit. J. med. Psychol.*, **22**, 169-82.
- THELEN, H. A. 1950. Educational dynamics: theory and research. *J. soc. Issues*, **6**, No. 2.
- . 1951. Experimental research toward a theory of instruction. *J. educ. Res.*, **45**, 89-93.
- THOMPSON, CLARA. 1950. *Psychoanalysis: evolution and development*. New York: Hermitage Press, Inc.
- TOLMAN, E. C. 1949. The psychology of social learning. *J. soc. Issues*, **5**, Supplement No. 3. Pp. 18.
- . 1951. A psychological model. Part 3 of T. PARSONS & E. SCHILS (eds.), *Toward a general theory of action*. Cambridge: Harvard University Press.
- TOMKINS, S. (ed.). 1943. *Contemporary psychopathology*. Cambridge: Harvard University Press.
- TRIST, E., & BAMFORTH, K. 1951. Some social and psychological consequences of the longwall method of coal-getting. *Hum. Relat.*, **4**, 3-38.
- U. S. WAR DEPT. 1945. Group psychotherapy record commentaries. *Tech. Bull. (Medical)* No. 103.
- VARON, EDITH. 1953. Recurrent phenomena in group psychotherapy. *Int. J. group Psychother.*, **3**, 49-58.
- VON NEUMANN, J., & MORGENSTERN, O. 1947. *Theory of games and economic behavior*. (2d ed.) Princeton: Princeton University Press.
- WAEELDER, R. 1933. The psychoanalytic theory of play. *Psychoanal. Quart.*, **2**, 208-24.
- WARNER, W. L., MEEKER, MARCHIA, & EELLS, K. 1949. *Social class in America: a manual for the measurement of social status*. Chicago: Science Research Associates.
- WARTEGG, E. 1939. Gestaltung und Charakter. *Z. ang. Psychol.*, Beiheft, No. 84.
- WEINGARTEN, ERICA M. 1949. A study of selective perception in clinical judgment. *J. Personality*, **17**, No. 4, 369-406.
- WENDER, L. 1940. Group psychotherapy: a study of its application. *Psychiat. Quart.*, **14**, 708-18.

- . 1951. Current trends in group-psychotherapy. *Amer. J. Psychother.*, **5**, 381-404.
- WERTHEIMER, M. 1912. Experimentelle studien über das sehen von bewegung *Zeitschrift für Psychologie*, **60**.
- WIEHE, F. 1934. The behavior of the child in strange fields. *Psychol. Forsch.*, **19**, 122-81. (Summarized in K. Lewin, 1935a, pp. 261-64.)
- WIENER, N. 1948. *Cybernetics*. New York: John Wiley & Sons, Inc.
- WILSON, A. T. M. 1951. Some aspects of social process. *J. soc. Issues*, Supplement Series, No. 5. Pp. 24.
- WOLF, A. 1949-50. The psychoanalysis of groups. *Amer. J. Psychother.*, **3**, 525-58; **4**, 16-50.
- WOLF, A., *et al.* 1952. The psychoanalysis of groups: the analyst's objections. Panel on group psychotherapy in private practice. 9th annual conf., Amer. Group Psychother. Assn., New York.





## INDEX OF NAMES

---

- Adler, A., 218, 241, 245, 300, 311  
 Allport, G. W., 274  
 Bach, G. R., 71, 73, 134, 135-36, 152,  
     154, 156, 157, 216  
 Bamforth, K., 370, 371  
 Barker, Gene, 154-55, 236-37  
 Baruch, Dorothy W., 137, 201  
 Bateson, G., 217, 224, 256, 265, 331  
 Baveles, Alexander, 64  
 Bergler, E., 70, 234, 404  
 Bion, W. R., 10, 19, 39, 41, 46, 47, 75,  
     96, 97-98, 112, 168, 178, 191, 216,  
     239, 240, 270, 273, 313, 317, 325,  
     344, 364, 365, 370, 371, 376, 379,  
     397  
 Bradford, L. P., 163  
 Bromberg, W., 21, 22  
 Brown, J. F., 338  
 Bry, Thea, 114, 281  
 Bühler, Charlotte, 197, 256, 354  
 Bühler, Karl, 154, 238  
 Burrow, T., 11, 221  
 Cameron, N., 19, 157, 244, 313  
 Cartwright, D., 338, 347-61  
 Coffey, H. S., 331  
 Conant, James, 216  
 Cook, S., 333  
 Crutchfield, R., 340-41, 373  
 Dembo, Tamara, 337  
 Deutsch, A., 103  
 Deutsch, M., 333  
 Dollard, J., 259, 398  
 Doob, L. W., 104, 259  
 Dreikus, R., 62  
 Durkin, Helen, 95, 100  
 Ezriel, H., 10, 47, 216, 239-40, 364-65,  
     369  
 Fairbairn, W. R., 230  
 Federn, P., 287, 289  
 Fenichel, O., 128, 234  
 Festinger, L., 338, 356, 357, 391  
 Fink, D. H., 201  
 Fiske, D. W., 395  
 Foulkes, S. H., 10, 38, 73-74, 216, 262,  
     324-25, 349, 357, 375, 378, 379  
 Frank, Jerome D., 10, 14, 16, 20, 25,  
     26, 31, 34, 50, 51, 58, 63, 67, 68,  
     102, 165, 204, 216, 240, 255, 335,  
     362, 363, 372, 376, 379, 409, 410  
 Franklin, G., 21, 22  
 Freedman, M., 331  
 French, J., 166, 338, 370  
 Freud, Sigmund, 92, 102, 115, 135,  
     159, 166, 200, 213-14, 234, 241,  
     258-59, 294, 311, 333-37, 338, 404  
 Fromm, Erich, 134, 135, 206  
 Gibb, J. R., 178, 179, 348  
 Giedt, H. F., 375  
 Goethe, Wolfgang, 226-27  
 Goldstein, K., 230, 297  
 Goodenough, Florence L., 136  
 Gordon, Thomas, 262, 333, 339  
 Graber, G., 234  
 Greco, M., 221  
 Guilford, J., 225  
 Gutheil, E., 55, 122, 132  
 Harlow, H. F., 256  
 Harrow, G., 160  
 Hobb, D. O., 362  
 Hemphill, J. K., 166  
 Henkley, R. C., 277  
 Hermann, Lydia, 277  
 Hobbs, N., 54, 67, 73, 132, 168, 339,  
     362, 372  
 Hogan, R., 230  
 Homans, G. C., 189-90, 325, 333, 349,  
     367, 368, 369, 376-77, 381  
 Horwitz, Selma, 152  
 Hull, C. L., 155, 201, 264, 323  
 Jahoda, Marie, 333  
 Jaques, E., 168  
 Jennings, Helen, 188, 276, 328-29, 330,  
     331, 395  
 Joël, W., 63, 376

- Jung, C. G., 136, 218, 403  
 Kelly, E. L., 395  
 Kinget, G. Marian, 137, 148  
 Klein-Lipshultz, Eva, 122  
 Knight, R., 21  
 Korzybski, A., 227, 276  
 Krech, 340-41, 373  
 Kretschmer, E., 241  
 Kupper, H., 133  
 Lawlor, G. W., 152, 160  
 Leary, T. F., 262, 331, 386, 387  
 Levy, D., 327, 396  
 Lewin, Kurt, 15, 39, 166, 190, 220, 233,  
     265, 318, 337, 338, 339, 340, 341,  
     346, 347, 348, 362, 365, 368  
 Lippitt, R., 166, 338, 351, 354  
 Lord, Edith, 395  
 Maas, Henry S., 16  
 Margaret, Ann, 19, 157, 244, 313  
 May, Rollo, 362  
 Mead, Margaret, 28, 162  
 Miller, H., 137, 201  
 Miller, J., 206, 291  
 Miller, Lorraine, 178  
 Miller, N. E., 104, 259, 398  
 Moreno, J. L., 11, 74, 132, 152, 153,  
     156, 188, 280, 328-29, 330, 331  
 Mowrer, O. Hobart, 193, 202, 294, 362  
 Murphy, G., 225  
 Murray, H., 10, 274  
 Newcomb, T. M., 359  
 Ossorio, A., 331  
 Pareto, Vilfredo, 367  
 Platts, Grace, 178  
 Polansky, N., 351, 354, 388  
 Powdermaker, Florence, 10, 14, 16,  
     20, 25, 26, 31, 34, 50, 51, 58, 63,  
     67, 68, 102, 165, 204, 216, 240, 255,  
     335, 362, 363, 372, 376, 379, 409,  
     410  
 Rank, O., 249, 258  
 Redl, Fritz, 39, 351, 354, 378, 388, 404  
 Reichenbach, H., 39, 218, 342  
 Rickman, J., 335  
 Riesman, D., 28, 255  
 Rogers, C., 230, 261, 295, 362  
 Ruesch, J., 217, 224, 331  
 Schacter, S., 81  
 Schilder, P., 11, 216  
 Sears, R. R., 159, 228, 259  
 Seward, G., 128  
 Shapiro, D., 63, 395  
 Slavson, S. R., 10, 22, 60-61, 98, 216,  
     391  
 Speer, E., 218, 241, 323, 337  
 Steinzor, B., 7  
 Sternbach, O., 257, 265  
 Sullivan, Harry Stack, 47, 216, 220,  
     239-40, 398  
 Sutherland, J. D., 10, 216, 239, 364-65  
 Tolman, E. C., 229, 260, 365  
 Trist, E., 370, 371  
 Varon, Edith, 16, 165  
 Von Wiese, L., 336-37  
 Waelder, Robert, 154, 156  
 Wartegg, E., 148  
 Wertheimer, Max, 264  
 Wesley, S. M., 334-35  
 Westie, C. M., 166  
 White, R. K., 166  
 Wiehe, F., 337  
 Wilson, A. T. M., 167  
 Wolf, A., 10, 35, 82, 92, 114, 121, 194,  
     216, 240, 257, 301

## INDEX OF SUBJECTS

---

- Absences from group sessions, 9
- Acceptance and support of the self "as is," 295-97
- Acting out, 114-16, 279, 281
  - damage resulting from, 116-17
  - danger of sexual, 410-11
  - misuse of, 115
  - psychopathic personalities, 21-22
- Activities
  - advice-giving, 95-107
  - organized, advantages of, 77-80
  - socializing, 107-20
    - analysis of, 107-11
    - spontaneous, 94-120
    - therapist initiated, 76-77
- Actors and artists, exhibitionism of, 304
- Advice-giving, 70, 94-107, 195, 231, 319
  - dynamic significance, 95
  - emotional gratification from, 95, 97, 102
  - motives for, 102-3, 105, 231-32
  - reporting experiences following, 106-7
  - and taking (theme 5), 70
  - therapeutic gains from, 104-5
  - transition from phase, 105-6
- Analyses
  - of effect of self on others (theme 16), 72, 194-97, 272
  - of effect others have on self (theme 15), 72, 194-97, 272
  - of social activities (theme 13), 72, 107-20, 271-72
  - of subgrouping (theme 12), 71, 385
- Analytical interpretative activities, work group engages in, 272
- Anger
  - at authority, 53
  - interpersonal contact and, 232, 233, 249
  - resistance differs from neurotic, 311-14
- Anxieties
  - anticipating, 36-37
  - collective, 362-63
    - difference between group tensions and, 363-65
  - forms and sources of, 362-63
  - group tensions and, 363
  - individual sessions relieve, 53-55
  - in early meetings, 36-49
  - reducing patients, 82, 364, 369, 370-74
  - socializing reduces, 111-13
- Assessment process, group, 178-91
  - frequency of, 189
- Associative compeering phase, 269, 273
- Atmosphere, of group, 4, 166
- Attendance, at group therapy sessions, 35
- Authority
  - anger at, 53
  - patients dependence on, 262, 377
  - place of, 346
  - sanctioned, of therapist, 353
- "Authority ridden" comments, 38
- Awareness of group process and role (theme 9), 71, 165-91
- Behavior
  - change from ego-centered to other-oriented, 52
  - compensation or counterphobic, 285
  - problems
    - acknowledgment of problem and conflict, 198
    - demonstration of unreality of defensive needs, 199-200
    - discovery of ways of utilizing environment, 200
    - pinning down instigation for, 198-99

- Behavior (*continued*)  
     reactive avoidance of problem, 198  
     recognition of unconscious needs, 199  
     sensing, 198  
     projective, 233-34
- Belonging or not belonging, from a clinical standpoint, 17-18, 220, 247, 255, 318, 348
- Blocks, communication, 360, 396
- Boundary awareness (theme 11), 71, 189-91, 346
- Catatonics, group therapy and, 18, 28, 323, 376
- Catharsis, creating opportunities for, 206
- Change, therapeutic, resistance toward, 294-314
- Character disorder, 300-1
- Children's doll play, 156-57
- Chronic monopolist, excluded from group, 19-21
- Clinical management (*see* Management, Clinical)
- Clinics, 12
- "Cliques," 345  
     managing tension caused by, 391-92
- Coalition, 395-96  
     aggressive-submissive peer, 408-9  
     defined, 395
- Cognitive fixations, impairment of contact capacity as function of, 241-46
- Cohesiveness, group dynamics, 338, 348-49, 352, 371
- Communications  
     blocking situation, 360, 396  
     drawings as form of, 137, 149-50  
     dynamics, 64-65  
     ego-strengthening effect of, 284  
     inhibition of free, 53  
     interpersonal, 261, 331  
     leader's authority as barrier to free, 377  
     levels of, 275-93  
         No. 1—stereotyped rational problem solving, 277-78  
         No. 2—nonstereotyped didactic-directive, 278-79  
         No. 3—cathartic verbalization and play, 279-82, 291  
         No. 4—testing of interpersonal effects, 282-86, 291  
         No. 5—contextual associations, 286-87, 290, 291  
         No. 6—self-perception, 287-89, 290, 291  
         No. 7—new problem solving, 289-93  
     network, 366-70  
     patient-patient, 359-60  
     semantic difficulties, 276  
     setting-in technique, 309-10  
     stimulating interpersonal, 172  
     themes of group, 67-80  
     verbal, 79
- Compensation or counterphobic behavior, 285
- Concepts  
     models and, of group life, 317-43  
     search for new, 4-5
- Confessions and symptoms (theme 1), 70
- Confluence  
     defined, 394-95  
     examples of, 395
- Consensus, group, 186, 205, 240, 298-99, 357-58  
     individuality and, 255-58  
     recognition of personal motives behind contributions to, 358  
     resistance against, 298-300  
     sitting-in technique, 310  
     subgrouping and, 394-413
- Contact operations  
     analysis of, 213-46  
     belonging and, 220  
     capacity of group member, 16-17  
     critical, 219  
     dynamics of neurotic, 220-23  
     impairment of contact capacity as function of cognitive fixation, 241-46  
     pathology, 218  
     principles of theragnostic technique, 223-27  
     psychology, 217-20, 227-31  
     social interests of neurotic patients, 234-35



- transference as special instance of, 213-15
- Continuous therapy groups, 12
  - therapeutic effects of, 34-35, 268
- Counterphobia, 245, 257, 285
- Countertransference, acting out, 399
- Creativeness, process of, 225
- Culture, groups, 59, 241
  - developing work, 3, 76, 79, 80
  - patients participation in building, 349
- Defense and mastery functions, 233-34
- Defense mechanisms
  - externalizing through activity programs, 78-79
  - understanding of, 244-45, 257
- Dependency problems, initial group, 42-43, 376, 380
- Depression, therapeutic, 251
- Diagnosis
  - communication level and, 282, 284
  - selection of members and, 12-27
- Differences, individual
  - group tensions aid in understanding, 370-71
  - groups must allow for, 356
- Differences between patients, effects of on groups, 355-58
- Discussions
  - cultural conventional repressions, 79
  - free-for-all, 73-75
  - spontaneous, of facts relating to personal history, 81-93
  - verbal, 79
- Disorder, group rejection of emotional, 101-5
- Distortions, 399
- Dominant character, excluded from groups, 19-21
- Dovetailing, socializing and neurotic, 113-14
- Drainage effects, individual therapy and, 50, 52, 60
  - Protocol No. 3 on, 57
- Drawings, projective, 42, 49, 71, 73, 121, 136-51
  - contribute to therapeutic process, 149-51
- group designs, 14
- insight mediated by repetitive, 139-40
- life perspectives, 143-44
- reflect nature of participation, 141-49
- resistance to, 138-39
- Round Robin, 139-40, 148, 149
- self-portraits, 137-38, 141-42
- Theme 8, 71, 139
- value of, 136-37
- views of group, 144-49
- wish fulfillment, 142-43
- Dreams, reporting and analyzing, 42, 48-49, 70, 92, 121-36, 226
  - about therapist, 127, 129
  - concerning relations with group, 125-27, 129-30, 226, 286
  - interpretation of, 55, 73, 122-23
  - protocols, 123-31
  - theme 6, 70
  - therapist role in group's work, 123, 128, 129, 130, 131-33
  - viewed as communications, 133-36
- "Dropouts," 104, 127, 301-2, 309, 356, 385
- Ego-defensive maneuvers of resistance, 36
- Ego growth
  - group participation contributes to, 247-67, 284, 292-93, 335
  - self-differentiation and, 247-67
- Emergency situations (theme 3), 70
- Emotional disorder, group rejection of, 101-5
- Emotions
  - basic, in group life, 273-74
  - factor in all phases of group development, 273-74
- Environment, ways of utilizing, 200, 247
- Environmental criteria for excluding new patients, 23-25
- Equilibrium, of group
  - definition of, 367
  - leadership helps maintain, 377-78
- Ethical confidence, in group psychotherapy, 30
- Exhibitionism, 162, 304
- Experiences, sharing of mutual, 30

- Externalization, 399
- Familial regressive phase, 269, 273, 319-22
- Family group  
   disintegration of, 327  
   model for therapy group, 322-28  
   reincarnated, 322-24  
   response fixation, 323  
   sociological studies, 326  
   therapy group relives experiences of, 81, 319-22
- Fantasy  
   dramatic, disturbed person and, 155  
   needs of patients, 244  
   play phase, 269-73, 274  
   role playing, 157-58
- Field theory, 6, 264  
   group dynamics, 340-43, 347
- "Fit" or role for acting out a set-up maneuver, 311-14
- Follow-up studies, 51, 166, 209, 309
- Free association, 194  
   communication level, 5, 286-87
- Freedom, group therapy and, 103
- Friends, differentiation between social and therapy, 117-20
- Frustration, interpersonal contacts, 232, 233, 313
- Gestalt approach to psychotherapy, 264-65
- Goals  
   groups, 30, 46-49, 180, 344-45  
   progress reports indicate patients' perception of, 107  
   of psychotherapy, 77, 217  
   structures, 46-49  
   values and (theme 2), 70
- "Going around," technique, 49, 72, 193-94, 287
- Gratification  
   conflict between group membership and individual, 258-60  
   group offers maximum, 261, 267  
   interpersonal relations, 285
- Group I, 7, 83, 109  
   length and frequency of meetings, 8  
   role playing, 152  
   themes discussed by, 69
- Group II, 7  
   dreams, 123  
   length and frequency of meeting, 8  
   protocol No. 18, 382-85  
   role playing, 152  
   sociometric questionnaires, 181  
   themes discussed by, 69
- Group-centeredness, developing, 38, 41, 76-77, 78, 116, 177, 180, 241, 270, 325, 346, 352
- Group dynamics  
   application of, to therapy group's, 344-61  
   basis of attraction of group, 350-51  
   criteria for selecting new patients, 25-27  
   deviants from norms of group, 355-58  
   emotional satisfaction derived from group participation, 350  
   factors of, that relate to changing individual behavior, 347-61  
   goal structure of group, 344-45  
   group's influence on behavior changes of members, 347  
   health of group and, 358-59  
   individual interaction and, 345-46  
   interpreting covert, 344-45  
   leadership and, 337-39  
   meaning of, 340-43  
   members with greatest prestige have greatest influence, 351-55  
   pressure of group, 356-58  
   principles applicable to group therapy, 345-47  
   processes of, 6  
   scientific study of, 337-40  
   self-regulating processes, 339  
   structure, 25  
   subgroup problems, 361  
   unconscious forces, 344-45
- Group psychotherapy  
   acceptance of, 28  
   admission of new members, 29-30  
   advantages of, 101, 192-93, 235, 263  
   awareness of group process and role (theme 9), 165-91  
   closed groups, 12  
   community or university clinic, 12

- conflict between individual and, 258-60
- continuous therapy groups, 12
  - therapeutic effects of, 34-35
- development of, 59, 270
- ethical confidence, 30
- examples of group self-regulation of programs, 169-78
- extraoffice meetings, 30; *see also* Sessions, post
- family group versus peer association as models for, 322-28
- fear reduction and authority, 168-69
- Gestalt approach to, 264-65
- history of, 11
- in-group-out-group phenomenon, 17-18
- individual therapy combined with, 13-14, 50-66
  - drainage effects, 50, 52, 57, 60
- individual treatment parallel with, 13-14, 58
- length of contact with, 9
- membership, 26, 29-30
- neurosis-inviting environment of, 104, 248-52
- participation in management of, 25-27, 30-31, 190, 192
- patients who show resistance to, 28-29, 43, 102, 104, 143, 258
- physical settings for, 6-7
- preparation and introduction of new patients, 28-35
- present approach to, 5-9
- principles of group dynamics applicable to, 346-61
- private consulting practices, 12
- problems of objective description, 9-11
- procedural principles, 29-30
- programs, 40, 72-80
- psychiatric hospitals, 12
- quality of emotional experience afforded participants, 37
- replacements or additions to, 17, 25, 26
- resistance phenomena in, 38-39, 294-314
- selecting new members; *see* Selecting new members
- size of group, 29
- subgroups, 71, 345, 361, 394-413
- terminating participation in, 248-49
- therapy group differs from family, 319-22, 324-26
- transference problems; *see* Transference
- trial group placement, 18, 21
- Groups
  - assessment process, 178-81
    - frequency of, 189
  - as a communication exchange, 331
  - concepts and models of group life, 317-43
    - change in, 338
    - history of, 318, 338
  - develop own characteristic life, 27
  - dynamics; *see* Group dynamics
  - Freud's psychology of, 333-37
  - leader role and group sanction, 167-68
  - methods of studying, 331
  - neurotic patient's fear of, 318
  - participant observations of group
    - process and role, 165-91
  - psychological nature of, 333-37
  - scientific study of, 337
  - as a sociometric choice pattern, 328-31
  - in terms of role structure, 331-32
- Guilt feelings, 258
- Harvard University, 179
- Here-and-now repetitive contact patterns, 115, 134, 162, 214-15, 218, 239, 242, 264, 271, 359
- Historical interpretation, issue of, 81-82
- Historical material
  - memory of past as defense against present threats, 82-88
  - role playing and, 155, 290
  - spontaneous discussion, 81-93
  - Theme 4, 70, 73
  - therapeutic use of, 89-93, 245-46, 290
- Homosexual affection, group sessions and, 53
- Hostility
  - advice-giving and, 102, 232, 324

- Hostility (*continued*)  
 expressing, 77-78, 298, 311, 405  
 toward therapist, 23, 96-97, 298, 311, 359, 405
- "Hot-seat" technique, advice-giving and, 309-10
- Hypnosis, in analyzing dreams, 135
- Hysterics  
 advice-giving and, 95-96  
 conversion, 92  
 group therapy, 82, 148, 303
- Identification, group, 34
- Improvement; *see* Therapeutic growth process
- Individual therapy  
 group-centered sessions and, 52-53, 54, 62  
 group therapy and, 14  
 group therapy combined with, 50-66, 75, 83, 406  
 need for individual consultations, 51  
 neurotic response to, 56-60  
 premature interpretations of latent emotions, 46  
 and role of group leader, 64-66  
 as a safety valve for group-generated anxiety and tension, 53-55  
 session as a stage for set-up operations, 56-60  
 for those resisting group, 29-39, 301  
 use of different therapist for, 60-63
- Individuality  
 common group tensions aid in understanding of, 370-71  
 group consensus and, 255-58  
 interpretative observations of, 192-203
- In-group consciousness phase, 269, 273-74, 392
- Initial situation testing phase, 269-73
- Insight  
 formation, 308  
 into patient's neurotic mechanisms, 195-96  
 pressure toward premature, 161  
 threatening self-insight, 297-300
- Interpersonal communication, group  
 offers new ways of, 261
- Interpersonal operation, 56
- Interpersonal problems, group members and, 62
- Interpersonal psychology, 5
- Interpersonal relations, 23  
 analysis of contact operation, 213-46  
 diagnosing individual's personal idiosyncrasies in, 192  
 "going around," 172-78  
 neurotic problems, 83  
 neurotic set-up operations, 231-34, 249-50, 399  
 peer associations, 327-28  
 psychiatrist as expert in, 47  
 role-playing methods, 161  
 sexual phase, 233, 234, 265-67  
 socializing and, 111-13  
 therapeutic in group therapy, 247-48  
 unsuccessful in building, 303
- Interpretation  
 issue of historical, 81-82  
 of latent emotions, 46  
 transference, 92  
 use of confrontations and, by therapist, 56, 81
- Interviews; *see also* Sessions  
 entrance, 13, 14  
 interpersonal relations, 16
- Intradermal conflicts, group therapy, 342
- Introducing new patients, 31-34  
 newcomers' reaction to first group, 32-34
- Isolates  
 arouse group tensions, 26, 381-93  
 distinction between social and clinical nonconformist, 392-93  
 group therapy for, 28-29
- Isolation, individual fear of, 308, 346
- Leader  
 dependence on, 39-41, 269, 273, 336  
 of initial group, 39-41  
 -follower coalitions, 408-9  
 -passive approach, 74
- Leadership  
 behavioral device to indicate need for active, 48  
 communication dynamics and, 64-65, 269



- by default, 38, 41, 47, 73, 75, 378-80
- degree of therapist's active, 41-46, 47, 48-49
- endogenous and "ill," 378, 379-81
- external pressures, 190
- functions of, 47-49, 331
- group dynamics, 337-39, 348-49
- group tensions and, 375
- leader role and group sanction, 167-68
- sanctioned role concept of, 167-68, 339, 353
- Learning
  - new process, 252
  - reinforcement of perceptual, 55-56
- Leary technique for measuring progress, 52
- Libido management, 265-67
- Life space drawings, 15-16
- Love, gratification of desire for, 247
- Lynching mobs, 259
- Management, clinical, 42, 73, 272
  - application of group dynamic principles, 344-61
  - authority role determination, 360
  - development and enforcement of norms, 360
  - function of, 369-70
  - group-centeredness as against leader-centeredness, 360
  - of group tensions, 370-74
  - patients' participation in, 360-61
  - problems, 186
  - of resistance resulting from direct pressure, 308-10
  - sitting-in technique, 309-10
- MAPS figure grouping, 15, 71
- Marital relationships, 29, 233
- Masochism, 291, 309
- Massachusetts Institute of Technology, 64
- Masturbation, as problem of group therapy, 410
- Maternal overprotection, 327
- Maturation process, 197
- Meetings; *see* Sessions
- Members
  - admission of new, 29-30; *see also* Newcomers
  - introducing new, 31-34
  - selecting new, 13-27; *see also* Selecting new members
- Membership, mastery of conflict between individual gratification and group, 258-60
- Memory, past as defense against present threats, 82-88
- Michigan, University of, 179, 337
- Minnesota, University of, 179, 337
- Mobs
  - Freud's views on, 317, 333-37
  - lynching, 259
- Models and concepts, of group life, 317-43
- Monopolists, habitual, in clinic groups, 19-21, 300-1
- Morale, factors increasing groups, 166
- Mother, dependency, 83-91, 124-25, 131
- Mutuality need, 28, 228-29
  - test to reveal, 15
- Narcissistic patients, group therapy and, 305-7
- Needs, recognition of unconscious, 199
- Neurosis
  - acquisition of, 264
  - communication concept of, 217-28
  - discovering nature of, 314
  - self understanding of, 292, 314
- Neurotic anger, resistance differs from, 311-14
- Neurotic pairing, 103, 114
- Neurotic patients
  - dynamics of neurotic contact, 220-23
  - group psychotherapy and, 235-41, 295, 324, 376
  - not tolerant of neurotic behavior in others, 103-4, 250-51
  - social interests of, 234-35
  - tensions and anxieties of, 53
- Neurotic touchiness and sensitivity as a theragnostic tool, 235-41
- Neurotic transference, 39, 41, 66, 111, 129
- Newcomers
  - arouse group tensions, 381-93

- Newcomers (*continued*)  
 group's concern with role of, 385-92  
 initial role setting, 386-92  
 introducing, 31-34  
 preparation of, 28-35  
 reaction to the first group meeting, 32-34  
 as a subgroup, 386-92
- Nonconformity, group's anxiety concerning, 198
- Norms, development and enforcement of, by group, 355-56, 360
- Observer, use of group, 63, 179
- Oedipal conflict, 241, 292, 335
- "Operation Me," ego growth and, 248-52
- "Operation We," ego growth and, 252-54
- Pace-setter, patient's identification with, 407-8
- Pairing, 397, 404  
 defined, 395  
 dynamics, 238  
 post-session, 108  
 function, 397  
 sexual, 409-13
- Parallel treatment, group and individual sessions, 60-61, 75
- Paranoids  
 group therapy, 41, 177, 234, 379-80  
 as leader-volunteers, 42, 143
- Parataxis, 237-39
- Parent-child fixations, 83-91, 124, 129, 335
- Parental influences, 83
- Participation in group  
 contributes to ego-growth, 3-4, 247-67, 284, 292-93, 335  
 in group management, 360-61  
 projective drawing reflect nature of, 141-49
- Patients  
 attitudes of, toward emotional disorder, 101-5  
 characteristics necessary for successful group therapy, 14  
 consultation among, 59-60  
 as co-therapist, 59-60, 400  
 excluded from group psychotherapy, 18-27  
 graduating, 252-53, 256  
 interest in group psychotherapy, 192-93  
 introducing new, 31-34; *see also* Newcomers  
 observations on group process and role, 165-91  
 participation in group management, 360-61  
 perceptions concerning each other, 282  
 prediction of group adjustment, 15-17  
 preparation of new patients, 28-35  
 recovery à deux, 407-8  
 referred, 13  
 rehabilitated, 252  
 replacements, 26  
 selecting, 13-27; *see also* Selecting new patients  
 socializing with each other, 114-16
- Peer association  
 differs from family group, 328  
 mediate therapeutic processes, 262, 348  
 model for therapy group, 322-38  
 significance of, 327-28
- Peer coalition, aggressive-submissive, 408-9
- Peer court  
 emotional satisfaction and, 95, 97  
 group therapy and, 94-98  
 therapeutic implications, 98-101, 104, 106, 262, 348
- Perception  
 gaining objectivity, 238-39  
 group, ahead of individual, 307  
 of neurotics, 236-37  
 of patients, of each other, 282
- Permissiveness, group therapy, 103
- Personal history, spontaneous discussion, 81-93
- Personality  
 changes as a result of group therapy, 261-64, 285, 303-4  
 criteria for exclusion from group psychotherapy, 18-22  
 development of, 83  
 disorders, 13

# Phases

- associative compeering, 269, 273
  - concept of, 196-97
  - developmental, in the therapeutic growth process, 268-93
  - factors of group dynamics common to all, 273-75
  - familial regressive, 269
  - fantasy and play, 269
  - in-group consciousness, 269
  - initial situation testing, 269
  - leader dependence, 269
  - oscillation among therapeutic growth, 201-2
  - seven phases of group's theragnostic work, 197-200
  - testing, 268-69
  - values related to developmental, 274-75
  - work phases, 268-70
    - clinical implications of, 270-73
- Phobias, role playing and extinction of, 155-56

# Play

- acting-out, 279-82
  - drama, 152
  - psychoanalytic theory of, 154
- Prediction of group adjustment, 15-17
- Preparation of new patients, 28-35
- steps in, 29-31
- Prepsychotics, 19
- Pressure; *see also* Consensus, group of group, 356-58
- individual resistance to majority pressure, 307-10, 390

# Prestige

- derived and felt, 352-55
  - influence of member related to, 351-55
  - sources of, in therapy group, 351-55
- Private practice, 12, 50-51, 303

# Problems

- focusing of group member's attention on others', 98
  - solving activities, 166
- Program; *see also* Themes
- clinical implication of therapist instigated, 73-75
  - examples of the group's self-regulation of, 169-78
  - free-floating discussions, 73-75

spontaneous versus programmatic themes, 72-80

strengthens group's autonomy, 76-77

Progress; *see* Therapeutic growth process

Projections, 399

Projective drawings; *see* Drawings

# Protocols

- use of, 9-10, 29
  - No. 1: A new patient's reaction to her first group therapy session, 32-33
  - No. 2: Therapist's first active participation—summarizing group emotions, 43-45
  - No. 3: "Drainage" in private sessions, 57
  - No. 4: "Mother," 83-88
  - No. 5: Individual session with patient six weeks after Protocol No. 4, 89-91
  - No. 6: "Reactivation," 92
  - No. 7: Example of Theme 13—Discussion of a birthday party, 109-11
  - No. 8: "Do Not Mix Therapy with Social Life," 118-19
  - No. 9: Dream reporting, 125-29
  - No. 10: H-F's first dream, 129
  - No. 11: H-F's second dream, 129-30
  - No. 12: H-F's third dream, 130-31
  - No. 13: Impromptu role acting, 153
  - No. 14: Reaction to a therapist's directiveness, 170-71
  - No. 15: To go or not to "Go Around," 173-78
  - No. 16: Group reaction to a resistant narcissist, 305-7
  - No. 17: Differentiation of family and therapy group, 321-22
  - No. 18: How the group attempts to use a newcomer to solve group tension over an isolate, 382-85
- Prudery, 302
- Psychegroup, 329-31, 395
- Psychiatric hospitals, group psychotherapy used in, 12
- Psychoanalysis, 6
- acting out and, 116
  - individual versus group in, 317-18
  - play, 154

- Psychoanalysis (*continued*)
  - resistance, strategies against, 294
- Psychodiagnosis, 13
  - procedures, 15-17
  - purposes, 13-14
- Psychodrama, 7, 42, 49, 70-71, 74, 132, 152-53, 280; *see also* Role-playing
- Psychologist, professional, 4
- Psychology
  - contact, 217-20
  - group, Freud on, 333-37
  - interpersonal, concepts for, 4-5
- Psychometric assessment (theme 10), 71, 178-81
- Psychopathic personalities, group-
  - destructive behavior, 21-22, 352
- Psychopathology, determining group member's, 14
- Psychosomatic disorders, 13, 20, 216, 218
- Psychotics
  - group therapy and, 18, 19, 236, 324
  - tensions and anxieties of, 53
- Questionnaires
  - follow-up, 51
  - sociometric, 180, 181, 182-89
- Rallying around a topic, 68
- Reactivation
  - of emotions belonging to family group, 319-22, 324
  - transferences and, 92-93
- Reality testing, group as a place for, 270, 303-5, 310, 314
- Recognition of unconscious needs, 199
- Recorder, group, 63
- Recovery à deux, 407-8
- Referrals, 13
- Rehabilitated patients, 252
- Reinforcement of perceptual learning, 55-56
- Release associations
  - defined, 395
  - examples of, 395-96
- Religion, psychotherapy and, 231
- Replacements or additions to group, 17, 25
- Reports, progress, 106-7
- Research, therapist and, 207
- Resistance
  - defensive, 39
  - ego-defensive maneuvers of, 36, 195
  - to group sessions, 28-29, 35, 43, 102, 104, 202-3, 294-314
  - hypothesis concerning the nature of, 202-3
  - individual resistance to majority pressure, 307-8, 412
  - latent group tension and, 38-39, 48
  - later, 36
  - management of early, 36-49
  - neurotic anger differs from, 311-14
  - resulting from direct pressure, 308-10
  - as a source of group tension, 294-314, 360
  - strategies of, 294-314
  - toward therapeutic change, 294-314
    - acceptance and support of self "as is," 295-97
    - adequate roles in social reality, 303-5
    - character disorder, 300-1
    - role fit and, 301-3
    - threatening self-insight, 297-300
  - transference, 39, 41
- Response patterns, personality changes and, 264
- Retrogression, under conditions of frustration, 319, 323
- Role-playing, 7, 152-64
  - advantages to be gained from, 160
  - children's doll play, 156-57
  - encouragement of patient-to-patient communications, 158-59
  - extinction of phobias, 155-56
  - "fit" for acting out a set-up maneuver, 311-14
  - function of, 275
  - group-needed, 331-32
  - impromptu role acting, 152-53
  - improvement of social skills, 159-60
  - limitations of techniques of, 160-64
    - anxiety evocation, 162
    - ego threat, 161
    - individual and cultural differences, 162
  - reactivation of deep historical material, 155, 290



- reinforcement of empathetic perceptions, 159
- sharing and reality testing of fantasy, 157-58
- substitution and mastery, 156-57
- symbolic role assignment, 186-87
- Theme 7, 70-71
- as therapeutic procedure, 153-60, 163-64
- therapy group selects roles, 301-3
- treatment complications, 160-64
- Sadism, advice-giving and, 98, 102-3
- Schizoid patients, 146, 164
- Schizophrenics, group therapy, 323, 410
- Screening technique, 13-14; *see also*
  - Selecting new members
  - importance of, in group therapy, 17
- Selecting new members, 13-27
  - to avoid sources of excessive tension and anxiety in group, 18
  - diagnostic procedures, 13-14, 207
  - environmental criteria for excluding, 23-25
  - group participates in, 25-27, 30-31, 190
  - intelligence factor, 27
  - members should be congenial, 350, 381-82
  - personality criteria for exclusion, 18-22
    - culturally tabooed or illegal behavior, 19
    - dominant character, 19-21
    - insufficient reality contact, 18-19
    - psychopathic defense and impulsiveness, 21-22
  - preparation sheet for new patients, 29-30
- Self-acceptance and support of the self "as is," 295-97
- Self-development, patient's interest in, 193
- Self-differentiation, against group background, 247-67
- Self-discrimination processes, 195
- Self-esteem, group living increases, 3
- Self-knowledge, group living increases, 3
- Self-other effects (theme 16), 194-97
- Self-perception, communication, 287-89
- Self-understanding, progression toward deeper, 284, 292
- Sensitivity, neurotic, as theragnostic tool, 235-41
- Sessions
  - attendance at, 35
  - between patients, 60, 404-6
  - early, 36-37
    - anxiety in, 36-49
    - management of early resistance, 36-49
    - newcomers' reaction to first group, 32-34
    - role-playing in, 161-62
    - social fear in, 39-41
    - tensions due to social fear and leader dependence, 39-41
  - first, 36-37
    - individual, 8-9
      - in addition to group, 9
      - for helping patients who have resistance to group psychotherapy, 104
      - subgroup experiences, 404-6
    - length and frequency of, 7-8, 261
    - neurotic behavior, 248-52
    - physical setting for, 6-7
    - post, 8, 30, 33, 65, 107-11
      - co-therapists, 108
      - subgrouping, 403
      - therapist does not attend, 8, 64, 107-8
    - programs, 169-78
    - round-table discussions, 7
    - schedule of, 7
    - seating arrangements, 7
  - Set-up operation
    - "fit" or role for, 311-14
    - subgroups and, 397-99, 403
    - and techniques of theragnosis, 231-34, 235, 249-50, 291, 311, 363
- Sex, patients learn to manage, 233, 234, 265-67
- Sexual impulses, group therapy sessions and, 53, 302
- Sexual pairing, 409-13
- Silences
  - new groups experience long, 46
  - peer court, 96

- "Sitting in" technique, 161, 308-10
- Sleep, mental functioning, 225
- Social activities, analysis of, 72
- Social behavior, neurotic patients and, 236
- Social fear, in initial groups, 39-41
- Social field
  - contact psychology and, 219-22
  - meaning of, 340-43
  - scientific study of, 339-40
- "Social incognito," 114-16
- Social interdependency, of individual and group, 271-72
- Social psychologists, 328, 331, 333
- Social reality, establishing, 303-5, 310, 314
- Social relations, as indicators of progress, 252-54, 262
- Socializing, 107-20
  - as anxiety reduction and interpersonal mending, 111-13
  - arguments against, 111-17
  - between patients outside of clinical sessions, 114-16, 392
  - differentiation of social friends from therapy friends, 117-20
  - neurotic "dovetailing" during, 113-14
- Sociogroup process, 330-31
- Sociological studies, family group, 326
- Sociologists, 328, 333
- Sociometric assessments, 165-91
  - technique, 180, 329, 353
- Solitude, function of, 225-26
- Sophisticated group, 270
- Speech, accidental slips of, 234-35
- Spontaneous activities, 72-73
  - advice-giving and socializing, 94-120
  - peer court, 94-101
- Strategies of resistance, 294-314
- Structure of therapy group, 77
  - subgroup, 71, 108-9, 113
- Subgroups, 345, 361, 394-413
  - analysis of, 71, 385
  - clinical functions in total group versus, 400-2
  - create isolates, 381
  - individual sessions with therapist deal with, 404-6
  - instigate group tensions, 394
  - managing tension caused by, 391
  - normal use and function of, 394-97
  - pathological uses of, 397-99
  - recovery à deux: identification with pace-setter, 407-8
  - as release device, 404-8
  - structure of, 394
  - subgrouping with individual patients, 407
  - therapeutically oriented, 402-4
- Subpsychotics, 19
- Symptomatology, culturally deviant, 19
- Symptoms and confessions (theme 1), 70
- Taboos, group meetings and, 259
- Tavistock Institute, London, 10, 239
- Techniques, 40; *see also* Management
  - dreams, 123, 128, 129, 130-33
  - group therapy, 40, 48
  - historical interpretation, 82
  - warm-up, 169, 171-78
  - drawings, 136, 138
  - "going around" 49, 72, 193-94, 287
- Tele process, group therapy and, 329-30
- Telephone, patient-patient contact by means of, 112-13
- Tension, group
  - clinical significance of, 362-74
  - common group tensions and individuality, 370-71
  - difference between collective anxieties and, 363-65
  - due to ill leadership, 355, 379-81
  - due to social fear and leader dependence, 39-41, 47, 48
  - equilibrium must be maintained between, 365-66
  - individual sessions relieve, 53-55
  - initial, 48
  - interpersonal contact and, 232
  - isolates raise, 381-93
  - latent group, 38-39
  - maintaining communication network in state of equilibrium, 366-70

- maintenance of social fields and equilibrium, 365-66
  - raised by leaders, 375-81
  - recognition of sources of, 373
  - subgroups instigate, 394
  - symptoms of group, 311
  - therapeutic tension management, 363
  - therapist's role with respect to initial group, 37-38, 47, 48
  - when group cannot influence member, 305-7
- Testing phase, of therapy group, 268-69
- Tests
  - psychological, 15-17
  - for referred patients, 13
- Themes
  - definition of, 67-68
  - of group communication, 67-80
  - major themes discussed by patients, 69-72
    - 1: symptoms and confessions, 70
    - 2: psychology, therapy goals, and values, 70
    - 3: emergency situations, 70
    - 4: historical perspective, 70
    - 5: advice-giving and taking, 70
    - 6: dream reporting and analysis, 70
    - 7: role playing, 70-71
    - 8: projective drawings, 71, 137
    - 9: awareness of group process and role, 71, 165-91
    - 10: psychometric assessment as technique to facilitate self-awareness, 71, 178-81
    - 11: boundary awareness, 71, 189-91, 346
    - 12: analysis of subgrouping, 71, 385
    - 13: analysis of social activities, 72, 107-20, 271-72
    - 14: going around, 72, 172-78, 193-94
    - 15: analysis of effect others have on self, 72, 194-97, 272
    - 16: analysis of effect of self on others, 72, 194-97, 272
  - related to various phases, 269
  - spontaneous versus programmatic, 72-73
  - wave unit, nature of, 68

Theragnosis, 192-203, 218-19, 272, 310

  - clinical technique of, 216
  - definition of, 192
  - neurotic touchiness and sensitivity as tool, 235-41
  - oscillation among therapeutic growth phases, 201-2
  - principles of theragnostic technique, 223-27, 235
  - set-up operations and techniques of, 231-34
  - seven phases of, 197-200

Therapeutic growth process, 34, 101, 103, 104

  - counterphobia personality change, 285
  - developmental phases, 268-93, 385
  - drawings contribute to, 149-51
  - gauging, 34
  - mediated by peers, 262
  - phases and, 196-97, 268-93
    - oscillation among phases, 201-2
    - seven phases of group's theragnostic work, 197-200
  - resistance toward, 294-314
  - subgrouping, 402-4, 407-8
  - technique for measuring, 52

Therapist

  - advice-giving activity and, 95, 97-98, 100
  - anxiety-reducing role, 78, 168-169, 409
  - aware of group tensions, 46, 168, 250
  - clinical task of, 27
  - degree of active leadership, 41-46, 47, 48, 167-68
  - depth, 104
  - does not attend post-sessions, 8, 64, 107-8
  - do's and don't's for, 204-9
  - dreams of patients and, 123, 128, 129, 130, 131-33
  - extent to which therapist should participate in the group, 405-6
  - focuses attention of group on itself, 326

Therapist (*continued*)

"going around" process and, 194  
 group dynamics and, 345-46, 348-49  
 hostility toward, 23, 45, 96-97, 98,  
     99, 109, 298, 311, 359, 376, 405  
 individual sessions, 50, 114  
 inexperienced, 378  
 initiates activities, 73-75  
 leader dependence in initial meet-  
     ings, 40-41, 132-33  
 leader role of, 10, 208, 239, 375,  
     379-81  
     by default, 38, 41, 47, 73, 75,  
     378-80  
     functions of, 47-49  
     group sanctions authority of,  
     167-68, 353  
 management of group tensions, 364,  
     369, 370-74  
 modeling by, 162  
 note taking by, 42-45  
 overt aspects of the role of, 204-9  
 patient as co-therapist, 400  
 patients assert superiority toward,  
     102, 138  
 patients' reaction to attitude of, 52,  
     127, 128-29, 297, 298, 323,  
     406-7  
 perceptual focusing, 46  
 preparation of new member, 31  
 prestige of, 351-55  
 programs instigated by, 73-75  
 reaction to suggestions of, 170-78  
 recognizes latent conflicts, 37  
 relation of patient to, 58-59, 62,  
     406-7, 413  
 rivalry or mutuality between pa-  
     tient and, 61  
 role of, 37-38, 47, 190, 356  
 summarizes group emotions, 42-45

task in individual session, 55  
 theragnostic process and, 240  
 use of different therapists for indi-  
     vidual sessions, 60-63  
 using two clinicians with same  
     group, 62-64

Touchiness, neurotic, as a theragnos-  
     tic tool, 235-41

## Transferences

acted out, 399  
 concepts beyond, 215-16  
 intensive, 56-60  
 neurosis, 39, 41, 66, 111, 129  
 process, 4  
 reactions to therapist, 128  
 reactivations and, 92  
 as a special instance of contact,  
     213-15

Treatment, termination of, 248-49,  
     252-53, 256

Unconscious, patient learns to share  
     his, 292-93

## Values

discussion of therapy goals and  
     (theme 2), 70  
 related to action tendencies of  
     group, 274

Visiting technique, 16-17

Weaning process, dependency prob-  
     lems and, 82-83, 91, 130, 272, 323

Wire recordings, 7, 29, 97

Work culture, developing, 3, 76, 79,  
     80

Work group phase, 269-70, 274  
 clinical implications of, 270-73  
 engages in analytical interpretative  
     activities, 272





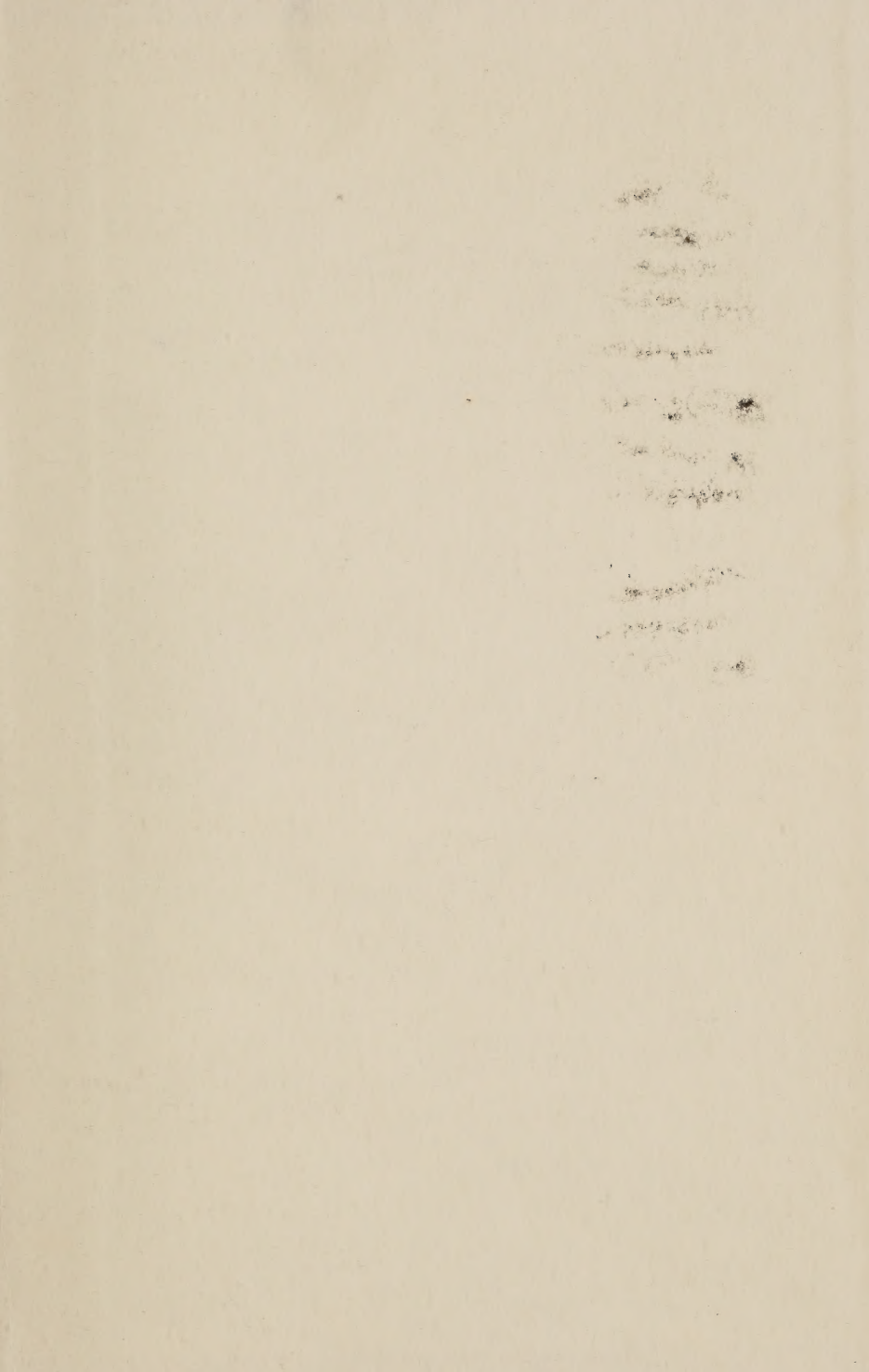




# DATE DUE

<del>MAY 24 '70</del>			
<del>DEC 8 '70</del>			
<del>11</del>			
<del>NOV 11 '70</del>			
<del>MAY 10 '70</del>			
<del>MAY 24 '70</del>			
<del>MAY 24 '70</del>			
<del>DEC 15 '70</del>			
DEC 7 '70			
<del>NOV 11 '70</del>			
<del>FEB 1 '71</del>			
<del>NOV 11 '70</del>			
<del>JUN 15 1970</del>			
<del>MAR 24 '70</del>			
<del>JUL 3 '70</del>			
GAYLORD			PRINTED IN U.S.A.





RC602.B11  
Intensive group psychotherapy.

Princeton Theological Seminary-Speer Library



1 1012 00146 7853